



New York State Department of Health
Delivery System Reform Incentive
Payment (DSRIP) Program

A Reference Guide for Behavioral Health
Projects Implementation Planning

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Introduction

The purpose of this document is to provide additional support for PPSs as they undertake the planning for the implementation of their behavioral health project(s). This document sets out considerations that PPSs can take into account during their ongoing implementation planning, continuing beyond May 1, the official submission date.

This document is not intended to be a prescriptive and exhaustive list of planning considerations, nor should it be considered prescriptive guidance regarding what “must” be included in formal implementation plans submitted to the Department of Health. All other DSRIP milestone and project requirements remain in place.

It is suggested that each PPS conducts its own internal assessment to identify resources, capabilities, and applicable goals. Additionally, the PPS should have a platform which allows open dialogue and input from all its relevant partners.

All projects should pay special attention to:

- ✓ Leadership and implementation team development.
- ✓ Developing a population health approach that is supported by core belief in the value of integration and of recovery.
- ✓ Identifying and working with attitudes, experiences, values, and expectations.
- ✓ Developing staff buy-in/engagement.
- ✓ Communication planning.
- ✓ Staff training in client engagement, including customer service, cultural and health literacy, and motivational interviewing.
- ✓ Information-sharing within and across internal and external care teams.
- ✓ Use of technology for improved communication between service providers, within teams, and between clients and clinicians.
- ✓ Medication management, as it relates to adherence, medication reconciliation between levels of care, and evaluation for drug-drug interactions.
- ✓ Incorporation of Health Homes into care management activities and development of a single plan of care, where beneficiaries are Health Home-eligible.

At any point, PPSs and their implementation teams may seek support from the National Council for Behavioral Health, a part of the DSRIP Support Team, by contacting their DST contact.



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

Financing and Regulations

All Models

- ✓ Site has obtained the necessary waivers, licensure, and/or certification to provide the additional on-site services, which may include, but are not limited to, inclusion of the new services on the clinic operating certificate and/or designation as an Integrated Outpatient Services clinic.
- ✓ All contracts with Managed Care Organizations have been negotiated to reflect delivery of on-site behavioral health services. Covered services might include Health and Behavior/Assessment Intervention codes, SBIRT, and brief psychotherapy.
- ✓ *Site has a plan early on to execute contracts with Managed Care Organizations that ensure adequate reimbursement for treatment interventions that are required elements of collaborative care models. These contracts may include fee-for-service, case rate, and pay-for-performance reimbursement schemes.
- ✓ Relevant personnel at individual sites have been trained on how to appropriately document and code for new line of services, such as SBIRT, behavioral health screenings, and Evaluation/Management codes.

Specific to Model 1: PCMH Service Site

- ✓ Relevant staff have completed an OASAS approved SBIRT training, which must be completed prior to offering and billing for SBIRT services.
- ✓ Article 28 clinics have secured waivers that allow individual and group psychotherapy services by licensed mental health practitioners, including clinical social workers.

Specific to Model 2: Behavioral Health Service Site

- ✓ Article 31 clinics have authority or secured waivers that allow for on-site preventive and evaluation and management services.
- ✓ *All contracts with Managed Care Organizations have been negotiated to reflect delivery of on-site primary care services with no medically unreasonable treatment limits and in keeping with state parity and other insurance laws.

Specific to Model 3: IMPACT

- ✓ Contract or employment agreement with psychiatrist established to reflect weekly scheduled consultation services to review cases of all new patients and those not improving. May also include providing additional and ongoing training to primary care staff on psychiatric issues.
- ✓ Article 28 clinics have secured waivers that allow individual and group psychotherapy services by licensed mental health practitioners, including clinical social workers.
- ✓ Behavioral health staff to be designated as depression care managers have received required training in assessment, engagement, psychoeducation, and brief psychotherapeutic modalities that are part of the IMPACT model.



Workforce

All Models

- ✓ *Sites have updated job descriptions for all staff, where necessary, to reflect new or revised roles and functions within an integrated health environment. See [SAMHSA-HRSA Center for Integrated Health Solutions section on workforce](#)¹ for resources.
- ✓ Staff responsible for care management responsibilities have been identified and trained.
- ✓ All staff, including client-facing administrative staff, have been trained in new protocols and their roles and responsibilities with respect to screening and treatment of behavioral health and physical health conditions.
- ✓ *Primary care and behavioral health staff have been trained on motivational interviewing (MI), and MI is built into ongoing training requirements and a plan for supervision to ensure the fidelity to the practice is in place.

Specific to Model 1: PCMH Service Site

- ✓ All client-facing staff complete training on basic behavioral health challenges most commonly seen in primary care, including depression, alcohol use, and anxiety, as well recognizing the signs and symptoms of more complex conditions. The team is trained in assessing and managing suicidal ideation, as well as when and how to engage the on-site behavioral health clinicians.
- ✓ The team is trained on when and how to refer to specialty behavioral health providers for additional support, such as when patients are not responding to treatment and/or patient needs exceed the capacity of the services available on-site.
- ✓ All prescribers complete training on prescribing standards for basic psychotropic medications for anxiety and depression, and on the impact of medications on substance abuse treatment.

Specific to Model 2: Behavioral Health Service Site

- ✓ All client-facing staff complete training on chronic illness management including common physical health medications, preventive care, and chronic conditions.
- ✓ Clinic incorporates into its clinical policies the implementation of U.S. Preventive Services Task Force recommended screenings for all clinic clients.

Specific to Model 3: IMPACT

- ✓ All prescribers complete training on the IMPACT model and prescribing standards for basic psychotropic medications for anxiety and depression.
- ✓ Relationship with consulting psychiatrist established for consistent and reliable availability to primary care providers to advise on cases that are complex or those not meeting expected outcomes.
- ✓ *Consider development of a consulting relationship with an Addiction Medicine specialist or Credentialed Alcoholism and Substance Abuse Counselor for instances where substance abuse or dependence issues may be the underlying reason for limited improvement.
- ✓ Care manager(s), at a minimum, and other staff have received training on Major Depressive Disorder symptomatology, physiologic effects, and biopsychosocial cycle; treatment options including antidepressant medications (basics of dosing and side effects), Cognitive-Behavioral Therapy, and Interpersonal Therapy; self-management support through education, behavioral activation, and Problem-Solving Treatment in Primary Care (PST-PC).

¹ <http://www.integration.samhsa.gov/workforce>



Clinical

All Models

- ✓ *Staff of different clinical backgrounds have opportunities to shadow one another.
- ✓ *Staff, both clinical and managerial, have opportunities to shadow existing integrated practices to learn about the ways in which integrated care is different from co-located care.
- ✓ Daily interdisciplinary team huddles to review current list of patients and ongoing development of team approach. Every other week interdisciplinary team meetings to focus on case consultation (at least monthly) and overall development of team approach.
- ✓ *Site has developed protocols for after-hours access to care, whether through expanded hours or after-hours call line for triaging urgent conditions; approach may vary for different service sites based on DSRIP or regulatory requirements and client need.
- ✓ Site has developed clinical registries or made appropriate arrangements with collaborators/vendors to access existing registries to support monitoring of target health conditions (e.g., depression, blood pressure, breath carbon monoxide levels for monitoring [smoking status](#)²).

Specific to Model 1: PCMH Service Site

- ✓ Protocols have been developed for universal screening for behavioral health conditions using evidence-based tools, including, at a minimum, use of PHQ-2 for depression and [OASAS-approved](#)³ screening tool for alcohol use.
- ✓ Positive screenings are followed by protocols for assessment, crisis/high risk response plan, and treatment, including integrated care plan, follow-up and management, and monitoring of response to treatment (e.g., re-administration of PHQ-9 at subsequent patient visits).
- ✓ Evidence-based protocols such as SBIRT are adopted for screening, assessment, crisis/high risk response plan, treatment including integrated care plan, follow-up, and management for target conditions with a plan to expand to other conditions (e.g., alcohol use, anxiety, depression).

Specific to Model 2: Behavioral Health Service Site

- ✓ Protocols are adopted for screening, assessment, crisis/high risk response plan, and treatment including development of an integrated care plan, follow-up, and management for at least one target condition (e.g., diabetes, hypertension, obesity, chronic pain).
- ✓ *Have a plan (including a timeline with target implementation dates) to expand to other conditions.
- ✓ *Behavioral health clinic policies and procedures reflect U.S. Preventive Services Task Force recommended screenings for all clinic clients, including lipids, hypertension, tobacco, alcohol, and breast/colon/cervical cancer.

Specific to Model 3: IMPACT

- ✓ Evidence-based protocols have been developed for universal screening of all patients with depression using PHQ-2. Positive screenings are followed by protocols for full screening with the PHQ-9, clinical assessment, crisis/high risk response plan, treatment including integrated care plan, follow-up, and management.
- ✓ Workflow and registries are created to track and trend PHQ-9 scores.

² http://www.omh.ny.gov/omhweb/consumer_affairs/lifespan/smoking_cessation/

³ <http://www.oasas.ny.gov/adMed/sbirt/index.cfm>



Organizational

All Models

- ✓ *Consider developing a consumer/patient advisory group that meets at least quarterly to provide insight and recommendations for integration design, quality, and outcomes.
- ✓ *An implementation work plan has been developed that addresses:
 - Initial and ongoing training needs of staff.
 - Sustainability issues, including an evaluation of new value-based financial models.
 - Reporting and project accountability.
 - The implementation work plan should incorporate a rapid-cycle change approach to on-going development of the integrated care model and practice improvement.

Specific to Model 1: PCMH Service Site

- ✓ *In addition to the retention of on-site behavioral health services, consider executing collaborative agreements with at least one outpatient specialty mental health and one outpatient specialty substance use treatment provider for patients requiring specialty behavioral health services beyond the scope of what is provided on-site. Collaborative agreements include, at a minimum: access to care standards for referred patients (including expedited admissions to ensure connection), follow-up report standards, and designated clinical lead at each organization for collaboration and communication plan for information sharing.
- ✓ Electronic Health Records have been updated to include decision supports and pathways of care based on positive screening for behavioral health conditions.

Specific to Model 2: Behavioral Health Service Site

- ✓ *In addition to the development of primary care capacity on-site, consider execution of a collaborative agreement with specialty providers to address conditions beyond the scope of what is provided at the behavioral health site. Collaborative agreements include, at a minimum: access to care standards for referred patients, follow-up report standards, and a designated clinical lead at each organization for collaboration and communication plan for information sharing.
- ✓ Space has been outfitted for medical procedures in accordance with DOH/OMH/OASAS regulations and/or Integrated Outpatient Services requirements.
- ✓ Electronic Health Records have been updated to include decision supports and pathways of care based on positive screening for physical health conditions.

Specific to Model 3: IMPACT

- ✓ A consulting agreement has been executed between the PCMH and a consulting psychiatrist to provide the clinical and supervisory services described in the IMPACT model.
- ✓ *Consider executing a collaborative agreement with at least one outpatient specialty mental health provider for patients requiring specialty behavioral health services outside of the scope of services provided through the IMPACT model. Collaborative agreements include, at a minimum: access to care standards for referred patients, follow-up report standards, and a designated clinical lead at each organization for collaboration and communication plan for information sharing.
- ✓ Electronic Health Records have been updated to include decision supports and pathways of care based on positive screening for depression and other clinical events identified in the IMPACT model.



Additional Work Plan Considerations

The development of integrated models of care, no matter the site or the approach, is a complex process that requires ongoing attention to change management and the development of the practice. Even for programs that have been working this way for several years, the lesson learned is that things can break down rapidly if there is not a structured approach to practice improvement. This can be addressed through continuation of regular leadership/implementation team meetings, with reporting and accountability to the project. The focus of these meetings evolves over time but includes:

- ✓ *Developing a rapid-cycle change approach to practice development (establishing targets, reporting and sharing data, revisions, retesting, sharing lessons learned).
- ✓ *Developing and testing workflow, connecting billing to new workflow.
- ✓ *Recognizing barriers and identifying strategies/solutions to staff buy-in/engagement.
- ✓ *Communicating early "wins", early lessons learned, early data, level-setting based on findings.

Categories of Risks and Potential Mitigation Strategies for Resolution

- *Risk category:* Differing cultures in primary care and behavioral health.
 - *Mitigation strategy:* This issue is addressed through careful attention to team development, shadowing to understand each other's roles, shared education on common issues that allows for conversation about mutual areas of practice, and acknowledgement of these issues.
- *Risk category:* Development of practice models as siloes; co-location, not integration.
 - *Mitigation strategy:* This issue must be addressed by the implementation/leadership team paying close attention to the development of the interdisciplinary team, along with a plan that includes clearly defined expectations and target dates for new clinical practice activities. Among the implementation strategies to facilitate integration are shared space use, shared records, regular meetings, morning huddles, and a process for immediately addressing breakdowns in communication or functioning.
- *Risk category:* Prevailing attitudes, judgments, expectations, and stigma toward behavioral health.
 - *Mitigation strategy:* The practice identifies these issues as they emerge in a non-judgmental/non-punitive way with a clear plan for education and intervention. The practice educates all staff on basic mental health/substance use disorder issues, preferably with some of the information presented by someone with lived experience. The practice could require a portion of CEU's/CME's for each type of staff to be in the other's world (e.g., physicians do CME on depression management, psychiatrist or Addiction Medicine specialist on management of comorbid medical issues, etc.). By noting and sharing success stories, the practice can continue to break down the myth that people with behavioral health issues do not get better.
- *Risk category:* Inadequately trained workforce.
 - *Mitigation strategy:* Implementation team accepts responsibility for survey of staff in terms of educational needs and provides a variety of opportunities for learning (e.g., formal continuing education, brown bag lunches, access to web based training, etc.). Training is ongoing and cyclical, not a single event. Evaluations include a focus on understanding of principles of integration, team member functioning, and continued practice development in the integrated context.



- *Risk category:* Fee for Service model of payment, including through managed care contracts, which may not reimburse adequately and/or reimburse at all for certain activities.
 - *Mitigation strategy:* Develop and test alternative payment models for integrated care that allow for the development of fully-integrated enhanced primary care models (i.e., per member per month, full risk, etc.). These alternative payment models also create an environment for the use of a more well-rounded multi-disciplinary team that includes community health workers, peer support staff, and recovery specialists to assist with culturally competent chronic disease management.
- *Risk category:* Inadequate capacity/resources, and/or financial instability of behavioral health provider safety net.
 - *Mitigation strategy:* Reallocate internal resources at the provider and/or PPS level to take on new, different, and/or additional work; dedicate attention by PPS governance to financial stability of individual, small provider practices and flow of funds to said practices.
- *Risk category:* Workforce shortages and/or discrepancy in salaries between PPS organizations.
 - *Mitigation strategy:* Within each PPS, attention will be paid to inequity in salaries between member organizations, and financing strategies will be developed to address this with an eye to staff retention.



Project 3.a.ii. Behavioral Health Community Crisis Stabilization

Contracts, Agreements, and Partnerships

- ✓ Establish agreements with the Medicaid Managed Care Organizations serving the affected population to provide coverage for the service array under this project.
- ✓ Establish agreements with at least one hospital with specialty inpatient psychiatric services, one hospital with specialty detoxification services, all PPS hospital emergency departments, all PPS health homes, all PPS outpatient mental health providers, all PPS outpatient substance use providers, and all PPS ambulatory detox providers (if available).
 - Agreements are formal contracts that include access and responsiveness standards (of both parties), information sharing standards, care coordination protocols, designated lead for each organization for clinical collaboration, staff training topics and frequency.
- ✓ *Ensure that providers of crisis services are licensed or designated by OMH/OASAS to provide specific crisis services described in the New York State Medicaid state plan or Home and Community Based Services benefit package.
- ✓ *Establish agreements for psychiatric and Addiction Medicine consultation services to the crisis team that include specific response times consistent with New York State and local regulatory body guidance.
- ✓ *Establish agreements for psychiatric assessment and treatment services for the consumer, in person or via telehealth, that include specific response times consistent with NYS and local regulatory body guidance.
- ✓ *Establish referral protocols with hotlines and peer-staffed [warmlines](#)⁴.
- ✓ *Develop work plans for outreach and education regarding triage protocol and value of triage and diversion for:
 - Emergency responders, including police and EMT
 - Community shelters
 - Schools and universities
 - Nursing homes and other residential centers
 - Behavioral health providers
 - Primary care providers
 - Consumer and advocacy groups
- ✓ *Market to community social service providers, health centers.

Workforce

- ✓ *Clinical staff retained are able to address mental health, substance use, and co-occurring mental health/substance use conditions; staff are also skilled in motivational interviewing and trained in SBIRT.
- ✓ *A staff training program and schedule (with specific target dates) are developed and include: suicide risk assessment and interventions, safety planning, crisis stabilization and de-escalation techniques, motivational interviewing, working with police, working with peers, mental health first aid or other first-responder interventions, cultural competency, health literacy, and community resources. See [Zero Suicide Toolkit](#)⁵ for resources.

⁴ <http://www.nyaprs.org/e-news-bulletins/2009/001428.cfm>

⁵ <http://zerosuicide.actionallianceforsuicideprevention.org/>



- ✓ *Plan for training on trauma-informed care to include:
 - The impact personal trauma experience has in being a driver of the crisis.
 - The fact that many crisis responses by providers are actually re-traumatizing or furthering the trauma cycle.
 - The need to care for staff, including elements of self-care and mutual support.
- ✓ *Development of supervision plan to include individual and group supervision.
- ✓ *Peer and recovery specialists are hired as staff with defined job functions that include:
 - Handoff to a [warmlines](#)⁴ for callers who primarily present to crisis team with need for talk support.
 - Use of targeted referrals to the [warmlines](#)⁴ for crisis consumers who would benefit from the engagement and normalization that a certified peer specialist can offer.
 - Inclusion on mobile crisis teams, used especially for people with newer diagnosis or new psychiatric and substance use disorder symptoms.
 - Providing immediate support to people in crisis and serving as an advisor to the rest of the team on the lived experience of crisis and helpful intervention strategies.
- ✓ *Employees are assessed for the beliefs, training, and skills needed to care for persons at risk of suicide, as described in the National Action Alliance for Suicide Prevention [Zero Suicide Toolkit](#)⁵.

Clinical

- ✓ *Consider inclusion of suicide loss and suicide attempt survivors in the review of all clinical and operational protocols.
- ✓ Identify and implement evidence-based tools to assess risk and stabilize crises. See [Zero Suicide Toolkit](#)⁵ for resources.
- ✓ Consider development of a protocol that deployment of the mobile crisis team results in a team debrief of the circumstances that lead to the deployment and how the crisis was addressed.
- ✓ Establish central triage center that includes:
 - Access to [warmlines](#)⁴.
 - Decision-making tools that lead to clinically appropriate interventions.
 - Ability to deploy staff rapidly.
- ✓ Development and monitoring of implementation of documentation guidelines, including same day documentation in EHR, but no later than 48 hours after the event.
- ✓ *Establish transition of care protocol, including personal contact by crisis team member during transition in care and within one week post-transition.
- ✓ *CQI plan in place for monitoring accessibility of non-crisis services, including, at a minimum, outpatient psychiatric and substance use disorder assessment and treatment. Accessibility is monitored for timely access to services and geographic access.
- ✓ *Explore creation of respite centers.



Organizational

- ✓ *Consider development of a hotline.
- ✓ *Consider development of peer-led warmline.
- ✓ *Consider use of telehealth for psychiatric services.
- ✓ *Consider use of out-stationed crisis team members at hospitals.
- ✓ *Consider use of communication software, text messaging capability.
- ✓ *If person is admitted to hospital, consider having the crisis team remain engaged until person is successfully connected to community-based inpatient or outpatient care, as needed.
- ✓ In keeping with overall emphasis on real-time data sharing, consider steps to assure electronic health records are interconnected and provide real-time data sharing with historical and current clinical data. Alerts and secure messaging functionality are used to facilitate crisis intervention services.
- ✓ *Consider mechanisms by which mobile crisis teams can have access to information when in the field (e.g., through smart phone technology that is easily accessible in challenging situations).
- ✓ *Consider creation of off-site, residential crisis program.

Categories of Risks and Potential Mitigation Strategies for Resolution

- *Risk category:* Hospital staff buy-in to diversion strategy and protocols (may feel “safer” to admit person).
 - *Mitigation Strategy:* CQI initiative with hospital and crisis program, adherence to agreed-upon protocols, ER and inpatient psych staff training on value of diversion and resources available. Team debrief of psychiatric admissions. ER staff training in [Zero Suicide](#)⁵ approaches—safety planning, lethal means restriction, rethinking suicidal ideation.
- *Risk category:* Emergency responder buy-in to diversion strategy and protocols (may feel “safer” to send person to hospital).
 - *Mitigation Strategy:* Strong, collaborative relationships with police and EMTs. Training on value of diversion and resources available. Documentation and publication of services provided, case studies; overall marketing effort.
- *Risk category:* Fee-for-service environment.
 - *Mitigation Strategy:* PPS fully funds crisis intervention program with levels of care including [warmline](#)⁴, respite services, peer support services, inter-disciplinary mobile crisis team, telehealth access to psychiatry, and technology to support these efforts.
- *Risk category:* Lack of community-based resources available.
 - *Mitigation Strategy:* Telehealth services when community-based services are not immediately available. Formal access and responsiveness agreements with community-based providers.
- *Risk category:* Lack of familiarity/willingness to use behavioral health crisis services among first responders (e.g., police) and other community service agencies.
 - *Mitigation Strategy:* Develop communication and marketing plan for outreach and engagement of first responders and other target community service agencies, and develop mechanism that allows first responders and others to provide feedback on utilization of the service.



Relationships/Stakeholders

- ✓ Emergency Responders: law enforcement and EMTs
- ✓ Nursing homes and residential centers
- ✓ Lived Experience community: survivors of suicide attempts, people with mental health or substance use disorders, family members/caregivers, etc.
- ✓ Mental Health providers
- ✓ Substance Use providers
- ✓ Health clinics
- ✓ Crisis Lines



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

Regulations and Contracts

- ✓ Contracts with Managed Care Organizations have been executed and reflect the service array under this project.
- ✓ Agreements have been drafted with outside entities (e.g., pharmacies, Managed Care Organizations, Health Home providers) that allow for necessary information sharing, in keeping with patient privacy requirements.

Workforce

- ✓ Identification and engagement of care team to primary care and other practitioners, care managers including Health Home care managers, social workers, and pharmacists who are engaged with the behavioral health population.
- ✓ Staff are trained based on the toolkit and training guide available through the [Fund for Public Health in New York](#)⁶ and the [NYCDHMH](#)⁷.
- ✓ *Key client-facing staff are also trained with other supportive approaches such as Motivational Interviewing and Health Literacy, as well as on SBIRT.
- ✓ *Staff are trained in technology support for medication adherence (i.e., phone based reminder systems, pill boxes, automatic medication dispensing systems, phone based check-ins, etc.)

Infrastructure Support

- ✓ *Organization has obtained all necessary medical equipment and prepared primary care space.
- ✓ *Organization has access to medications and is able to safely maintain medications.
- ✓ Electronic Health Records have been updated to include decision supports and pathways of care based on positive screening for depression.
- ✓ *An implementation work plan has been developed that addresses:
 - Ongoing training and re-training needs of staff.
 - Sustainability issues, including an evaluation of possible financial models.
 - Reporting and project accountability.
 - Refining of population health approach from first phase.
 - Rapid-cycle change approach to on-going development of the integrated care model and practice improvement.

⁶ <http://fphny.org/programs/medication-adherence-project>

⁷ <http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-map-tools-manual.pdf>



Protocols and Care Coordination

- ✓ *Program eligibility criteria are clearly defined.
- ✓ *Program has protocols in place with community partners including pharmacists, treatment programs, and other special services for referrals, triage, and assessments.
- ✓ *Acute care protocols are in place to assess and transfer patient if a higher level of care is warranted.

Categories of Risks and Potential Mitigation Strategies for Resolution

- *Risk category:* Prevailing attitudes, judgments, expectations, and stigma toward behavioral health.
 - *Mitigation strategy:* Identification of these issues as they emerge in a non-judgmental/non-punitive way with a clear plan for education, intervention, etc. Minimal baseline education of all staff from front door to back door on MH and SUD conditions, psychotropic medications, and medication adherence strategies, preferably with some of the information presented by someone with lived experience.
 - *Mitigation strategy:* The clinical approach from the prescriber to all other staff must be one of [shared decision making](#)⁸ that does not look at lack of adherence as willful manipulation or refusal but based in reason that has to be discovered and addressed.
- *Risk category:* High rates of “no show” appointments.
 - *Mitigation strategy:* The clinic’s policies around access to services are designed to allow for walk-ins and urgent and semi-urgent refill requests.
- *Risk category:* Workforce training and cross-training.
 - *Mitigation strategy:* Implementation team accepts responsibility for survey of staff in terms of educational needs and provides a variety of opportunities for learning (e.g., formal continuing education, brown bag lunches, access to web based training, etc.).

Relationships/Stakeholders

- ✓ Pharmacy or other medication dispensary services
- ✓ Primary care providers
- ✓ All levels of outpatient addiction treatment
- ✓ Residential providers
- ✓ Criminal justice
- ✓ Mental health
- ✓ Social service providers (e.g., child welfare, homeless)
- ✓ Health centers
- ✓ Health homes

⁸ <http://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf>



IT Needs

- ✓ *Capability to produce Continuity of Care documents.
- ✓ Electronic records to monitor and track progress, and that are integrated across network of care providers.
- ✓ *Decision support software for providers to support them in finding medication with maximum positive effect and minimal side effects.

Additional Work Plan Considerations

- ✓ *Plan for integrating tracking and reminder technology (e.g., online education, apps for remote support).



Project 3.a.iv. Development of Withdrawal Management Capabilities and Appropriate Enhanced Abstinence Services within Community-Based Addiction Treatment Programs

Regulations and Contracts

- ✓ Contracts with Managed Care Organizations have been executed and reflect the service array under this project.
- ✓ Organization has obtained the licensure or waivers necessary in order to perform ambulatory detoxification services (e.g., Part 816 designation or waiver to provide detoxification services as a Part 822 provider).
- ✓ *Organization has obtained written approval from OASAS for any space use alterations.
- ✓ Formal referral and care coordination agreements are in place with the continuum of recovery and treatment supports, including:
 - Peer recovery coaches for individual and group support
 - All [LOCADTR](#)⁹-defined levels of care

Workforce

- ✓ Retained a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone, as well as familiarity with other withdrawal management agents.
- ✓ *Developed a staff training protocol that includes ability to address detox from alcohol, opiates, and sedatives, differentiation between withdrawal management agents, assessment and evaluation of mental health needs, and appropriate referral relationships in place if MH services needed (including access to mental health medications). Training protocol includes continuing education and use of the [LOCADTR](#)⁹ tool required by OASAS.
- ✓ *Staff are trained in Motivational Interviewing (MI) and are equipped to provide education about the process of treatment and what to expect.
- ✓ *Job descriptions and organizational training protocol reflect that staff are co-occurring capable.
- ✓ *Care managers are able to identify community support resources including transportation, child care, housing, and employment training.

Infrastructure Support

- ✓ *Organization has obtained all necessary medical equipment and prepared primary care space.
- ✓ *Organization has access to medications and is able to safely maintain medications.

Protocols

- ✓ *Program eligibility criteria are clearly defined and align with OASAS levels of care.
- ✓ *Program has developed assessment and screening criteria and protocols to gauge appropriateness for outpatient detoxification level of care.

⁹ <https://www.oasas.ny.gov/treatment/health/locadtr/index.cfm>



- ✓ *Program has developed procedural work flow for triage, assessment, and determination of appropriateness for level of care.
- ✓ Program has protocols in place with community partners for referrals, triage, and assessments; counselors are available for initial evaluation within agreed-upon timeframe.
- ✓ Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.
- ✓ *Clients have 24-hour access by telephone, either directly to program or via hotline, to assist in recognizing symptoms of withdrawal, when to take additional medication, and under what circumstances to go to the nearest emergency room.
- ✓ *Program has access to or arrangements for transportation to allow for seamless transitions between levels of care and from community providers to the program.
- ✓ *Acute care protocols are in place to assess and transfer patient if a higher level of care is warranted.

Outreach and communication, including training partners on referral protocol/criteria

- ✓ *Identification of key partners. Key partners include: Hospital, ER, all levels of outpatient addiction treatment, residential providers, criminal justice, mental health, other social service providers (e.g., child welfare, homeless), health centers, crisis and other intervention hotlines.
- ✓ *Training key partners on screening.
- ✓ *Develop transportation plan to allow for seamless transitions.

Care Coordination and Connection to Treatment

- ✓ Develop care management services within the SUD treatment program.
- ✓ *Linkages to treatment.
- ✓ *Evaluation/assessment for best recovery and support resources, and treatment resources.
- ✓ *Develop stepped levels of care for care coordination and treatment to facilitate treatment engagement.
- ✓ *Ensure that internal or partner have the array of services at varied levels of care to support continued treatment needs, such as OASAS outpatient and residential care.
- ✓ *Linkages to recovery supports – 12-step peers, peers, recovery coaches.
- ✓ *Linkages to community supports – housing, employment.
- ✓ *Coordination with health homes.
- ✓ *Partner treatment provider engaged in transfer/treatment planning.

Categories of Risks and Potential Mitigation Strategies for Resolution

- *Risk category:* Co-occurring capabilities of staff.
 - *Mitigation Strategy:* Staff trained to evaluate and assess mental health (e.g., suicidality). Have consulting psychiatrist or other mental health provider available.
- *Risk category:* Lack of available treatment and supportive services.
 - *Mitigation Strategy:* Formal attention to identification of a continuum of services, and development of formal relationships with specific providers (through contracts, MOUs, or other means of gaining shared understanding).



- *Risk category:* Service level is not appropriate for individual client (e.g., for ambulatory detox, individuals must have some level of community support and stability).
 - *Mitigation Strategy:* Robust triage process that includes community partner education about eligibility criteria; assessment reflects [LOCADTR](#)⁹ level of care tool integration to determine ambulatory detox level of care and utilization of an OASAS-approved assessment.
- *Risk category:* Detox process needs to be based on a personalized plan rather than one-size-fits-all length of time. Like other complex, chronic diseases, care intensity and duration should be based on several factors such as how long the person has been using substances, what substances, etc.
 - *Mitigation Strategy:* Solid initial and ongoing assessment, and clear utilization criteria with payers.

Relationships/Stakeholders

- ✓ Hospital
- ✓ ER
- ✓ All levels of outpatient addiction treatment, namely outpatient, intensive outpatient, and day rehabilitation
- ✓ Residential providers
- ✓ Criminal justice
- ✓ Mental health
- ✓ Social service providers (e.g., child welfare, homeless)
- ✓ Health centers
- ✓ Crisis and other intervention hotlines

IT Needs

- ✓ *Capability to produce Continuity of Care documents.
- ✓ Electronic records to monitor and track progress.

Additional Work Plan Considerations

- ✓ *Plan for day support and tracking technology (e.g., online education, apps for remote support).



Project 3.a.v. Behavioral Interventions Paradigm (BIP) in Nursing Homes

Regulations and Contracts

- ✓ Contracts with Managed Care Organizations have been executed and reflect the service array under this project.
- ✓ Staff who are able to bill Medicare and Medicaid are hired or regulations are waived to allow a more diverse pool of professionals to provide behavioral health services in the nursing home.

Workforce

- ✓ Identification of key new professional staff: Nurse practitioners and psychiatric social workers who have skill and training specifically in working with the geriatric population and who also have training/staff education abilities and skills.
- ✓ *Train key professional staff in appropriate clinical models, including crisis intervention strategies that do not require automatic hospitalization but use existing resources in the SNF to provide support on-site.
- ✓ For SNF staff, provide training, education, and support in basic behavioral health conditions impacting residents of SNF and basic intervention strategies.
- ✓ *Support workforce in evaluating the environment as one component that is potentially triggering to people. Assist in developing alternative activities for residents.
- ✓ *All staff increase their knowledge in behavioral strategies to deal with agitation, sleeplessness, anxiety, depression, and behavioral manifestations and symptomatology of substance use disorders and, in some cases, cravings, to decrease the use of medication.
- ✓ *All staff are trained in pain management strategies, identification of pain in people who are non-verbal, and methods of intervention (pharmacologic and non-pharmacologic).

Infrastructure Support

- ✓ *Organization has access to medications and is able to safely maintain medications.
- ✓ Electronic Health Records have been updated to include decision supports and pathways of care for behavioral health issues that appear in the elderly SNF population.
- ✓ *An implementation work plan has been developed that addresses:
 - Ongoing training and re-training needs of staff.
 - Sustainability issues, including an evaluation of possible financial models.
 - Reporting and project accountability.
 - Rapid-cycle change approach to on-going development of practice improvement.

Protocols

- ✓ *Program eligibility criteria are clearly defined.
- ✓ *Acute care protocols are in place to assess and transfer patient if a higher level of care is warranted, but as a last resort.



Categories of Risks and Potential Mitigation Strategies for Resolution

- *Risk category:* Prevailing attitudes, judgments, expectations, and stigma toward behavioral health.
 - *Mitigation Strategy:* Identification of these issues as they emerge in a non-judgmental/non-punitive way with a clear plan for education, intervention, etc. Minimal baseline education of all direct care staff in BH issues, helping them move to non-judgmental approach and increased confidence in their skill at dealing with challenging behaviors.
 - *Mitigation Strategy:* The clinical approach looks at antecedents of challenging behaviors and assists all staff in finding various approaches and solution.
- *Risk category:* Workforce training and cross-training.
 - *Mitigation Strategy:* Implementation team accepts responsibility for survey of staff in terms of educational needs and provides a variety of opportunities for learning: formal continuing education, brown bag lunches, access to web-based training, etc.

Relationships/Stakeholders

- ✓ Primary care providers who come into SNF
- ✓ Emergency transport staff from local community
- ✓ All ancillary staff and executive staff in SNF are trained in and understand this approach
- ✓ Family/support people

IT Needs

- ✓ *Capability to produce Continuity of Care documents.
- ✓ Electronic records to monitor and track progress.
- ✓ *Decision support software for providers to support them in finding medication with maximum positive effect and minimal side effects.