Add Behavioral Health Goal and Domain 6 – Behavioral Health

- Project 1.1 Increase access to SUD care and system-wide SUD treatment capacity

- Project 1.2 Expand the SUD Continuum of Care and provide the needed infrastructure to address chronic nature of disease
  - DMC coordinated care initiative authorizes some of the treatment continuum, but not the infrastructure support needed by providers and counties to make it happen.
  - Homelessness
    - Active Outreach and Engagement in Community Setting & Transportation Assistance for Linked Referrals
  - Case Management
  - Care Coordination – Behavioral Health Homes
  - Medication Assisted Treatment
  - Whole person care to address other chronic medical diseases (e.g., diabetes, asthma, obesity) in conjunction SUDs

- Project 1.2 Enhance quality of SUD care providers and professional staff

- Project 1.3 Expand Use of EHR and Information Technology in SUD Treatment (as MHSA did for MH)

Integration of Behavioral Health, Primary Care & Acute Care

- Two-way Integration: Also bring primary Care Into Behavioral Health as demonstrated and supported by SAMHSA PBHCI grants – 12 grants awarded in California Since 2010
- Remove barriers to care integration in residential SUD treatment regulations
- Beyond Primary Care: Strengthen cooperation and coordination of care between SUD and MH treatment providers and acute care hospitals - in Emergency Departments and beyond. The hospital setting may be the only opportunity to contact homeless and severe SUD cases.
  - Reduce hospital bed days for SUD related care
  - Reduce unnecessary Medical and Psychiatric ER use for SUD related crisis
  - SBIRT in Hospitals
    - Staffing by behavioral health specialists will assure capacity to do brief intervention and referral – not just screening
  - Improve access to psychiatric evaluations in hospitals (telehealth) to reduce hold times and increase ED capacity
  - Improve linkages (e.g., staff and transportation) between hospitals and ERs to community-based providers of SUD
  - Expanded behavioral health role in discharge planning
    - Includes step down to less expensive care
  - Electronic communication of admissions and discharges to assure timely notification

Table 1. Potentially Preventable Readmission (PPR) Rates per 100 At Risk[1] Admissions by Medicaid Recipient Health Condition at Initial Admission and Region: New York State, 2007

	New York City			Rest of the State			New York State		
Recipient Health Condition	Initial Admissions [1]	At Risk Events [2]	PPR Rate	Initial Admissions	At Risk Events	PPR Rate	Initial Admissions	At Risk Events	PPR Rate
Mental Health	6,808	79,815	8.5	3,715	52,116	7.1	10,523	131,931	8.0
Substance Abuse	4,111	35,578	11.6	1,523	19,291	7.9	5,634	54,869	10.3
Mental Health and Substance Abuse	13,043	62,409	20.9	7,833	54,081	14.5	20,876	116,490	17.9
All Others	6,485	132,269	4.9	2,567	56,234	4.6	9,082	188,503	4.8
Total	30,447	310,071	9.8	15,638	181,722	8.6	46,115	491,793	9.4

[1] Non-excluded admissions followed by at least one clinically related readmission.

[2] All inpatient events that were not excluded according to defined PPR criteria.

https://www.health.ny.gov/health_care/managed_care/reports/statistics_data/3hospital_readmissions_mentahealth.pdf