3.a.ii: Behavioral Health Community Crisis Stabilization Services

Project Champion- TBD
Project Manager- TBD

Goal: 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.

Project Description: A crisis intervention program that, at a minimum, includes outreach, mobile crisis and intensive crisis services.

Counting Method #2: A count of patients that meet the criteria over 1 yr. Duplicate counts *ARE* ALLOWED. Count is NOT ADDITIVE across yrs.

Actively Engaged	Data Source	Q&A What is a valid count
Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements	Own registry	Q. How do we define one instance of crisis stabilization? A. A count for crisis stabilization includes all activities for that one patient to help them back on their feet after an episode: treatment/follow-up. A readmission/relapse counts as another instance for that patient. Q. Does any reason for using crisis stabilization count? A. We are going to assume that anyone utilizing is utilizing appropriately. Q. What do we mean by 'participating patients'? A. Patient population is community based persons experiencing an acute psychotic episode or otherwise behavioral unstable which would generally result in ED/hospital use but who are diverted to the crisis stabilization service; one instance is one acute psychotic episode.

DSRIP Performance Metrics - Domain 3: Behavioral Health - All behavioral health projects use the same metrics

Name (Measure)	Measure Steward	Data Source	DY 2-3	DY 4-5
PPV (for persons with BH diagnosis) + -	3M	NYS DOH	P4P	P4P
Antidepressant Medication Management	NCQA	NYS DOH	P4P	P4P
Diabetes Monitoring for People with Diabetes & Schizophrenia	NCQA	NYS DOH	P4P	P4P
Diabetes Screening for People with Schizo./BPD Using Antipsychotic Med.	NCQA	NYS DOH	P4P	P4P
Cardiovascular Monitoring for People with CVD and Schizo.	NCQA	NYS DOH	P4P	P4P
Follow-up care for Children Prescribed ADHD Medications	NCQA	NYS DOH	P4R	P4P
Follow-up after hospitalization for Mental Illness	NCQA	NYS DOH	P4P	P4P
Screening for Clinical Depression and follow-up	CMS	PPS	P4R	P4P
Adherence to Antipsychotic Medications for People with Schizophrenia	NCQA	NYS DOH	P4P	P4P
Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	NYS DOH	P4P	P4P
PPV (for persons with BH diagnosis) + -	3M	NYS DOH	P4P	P4P

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PPS Project Champion- TBD
Project Manager- TBD

Speed Commitment: All Participating Sites Will Meet All Project Requirements					
DSRIP Year	Calendar Year	Q1	Q2	Q3	Q4
DY1	4/1/15-3/31/16	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
DY2	4/1/16-3/31/17	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
DY3	4/1/17-3/31/18	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
DY4	4/1/18-3/31/19	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
DY5	4/1/19-3/31/20	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar

The Project Requirements Document can be found here:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_domain1_project_requirements_milestones_metrics.pdf

Patient Engagement Speed	**DY0**		**DY1**		**DY2**		**DY3**		**DY4**	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	0	0	**8274**	**20684**	**15738**	**31475**	**22483**	**44965**
Expected # of Actively Engaged Patients	44965	44965	44965	44965	44965	44965	44965	44965	44965	44965
% of Patients *Actively Engaged*	0%	0%	0%	0%	18%	46%	35%	70%	50%	100%

Participating Regional Health Innovation Teams: Fulton, Queensbury, Northern Adirondack