The New Face of Healthcare:

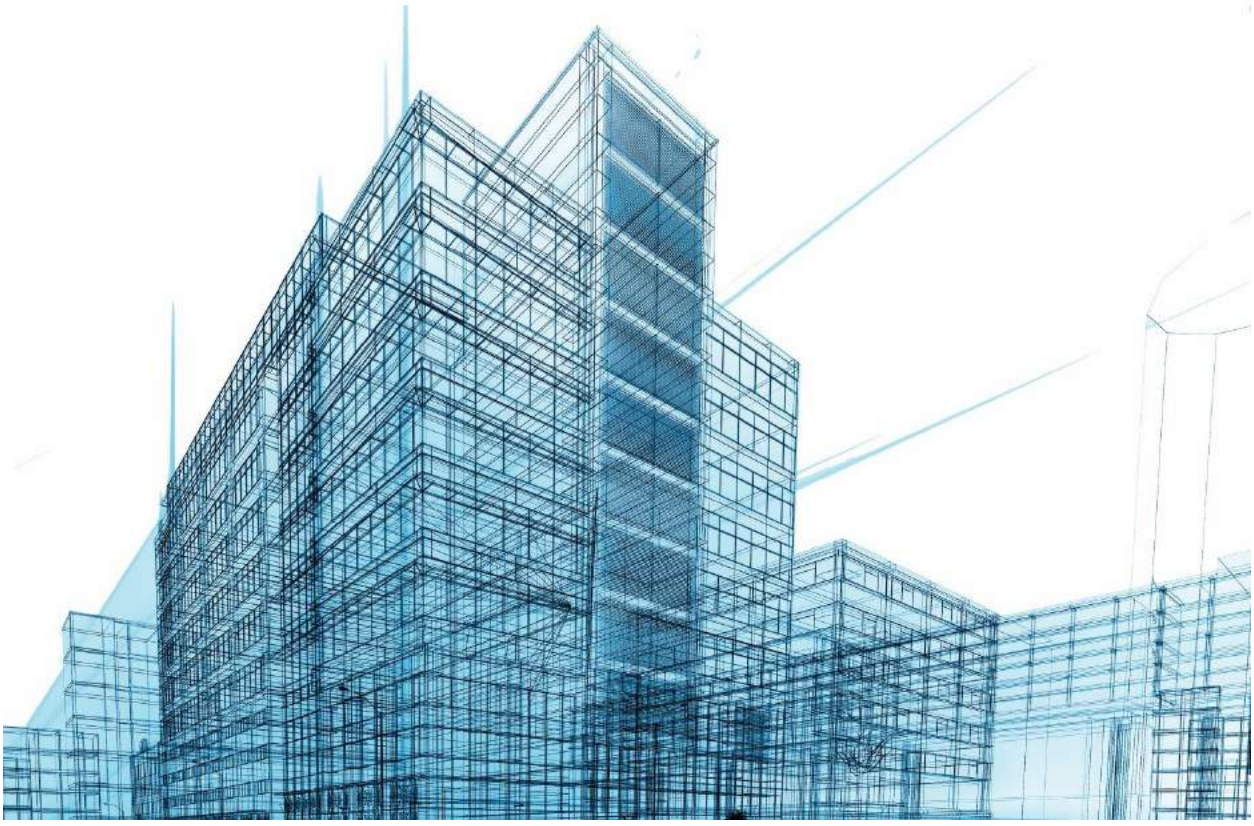
Building an Integrated System of Care in Suffolk County

Blueprint for Collaboration

Suffolk Care Collaborative

COS Communities of Solution

Long Island Health Collaborative



Section 1: DSRIP Overview

DSRIP & Program Overview

Background

In response to rising healthcare costs, Medicaid spending and concerns of health care quality, Governor Andrew M. Cuomo created the Medicaid Redesign Team (MRT). The MRT initiatives accounted for approximately $17.1 billion in federal savings. On April 14, 2014, Governor Andrew M. Cuomo announced New York finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion of federal savings generated by the MRT reforms. The MRT waiver amendment goal is to transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members. NYS Department of Health's charter under this waiver to fully implement an action plan to allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) Program.

State-wide Effort: Delivery System Reform Incentive Payment Program

Through the Delivery System Reform Incentive Payment Program, a grant waiver administered by the NYS Department of Health (NYS DOH), $6.42 billion Medicaid dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient-focused system to a community-facing system that addresses both medical needs and social determinants of health. DSRIP is a 5-year, performance payment-based program with primary goal of reducing avoidable hospital use by 25% over 5 years. At the end of the program life, the aim is for the newly-transformed system is to be sustainable. Project efforts are focused on achieving improved overall health through integration of behavioral health and primary care, provision of appropriate levels of care management, and care delivery models designed to improve chronic disease prevention and outcomes.

Local Leadership: Suffolk Care Collaborative

New York State is broken into 25 regional organizations called Performing Provider Systems (PPS). Each PPS is responsible for engaging providers, designing programs, coordinating collaboration, reporting project outcomes and allocating funds to partners.

The Suffolk Care Collaborative (SCC) is the PPS for Suffolk County under the DSRIP Program. The goal of SCC is to meet the requirements of the Triple Aim Initiative – improving patient experience, improving health outcomes and reducing the per capita cost of healthcare. Our vision to become a highly effective, accountable, integrated, patient-centric delivery system has positioned us well to make an important contribution to the DSRIP program. Some of the many goals will include the capacity to make the most of patients' self-care abilities, improve access to community-based resources, break down care silos, and reduce avoidable hospital admissions and emergency room visits.

Transition of Care Program for Inpatients & Observation Units

The objective of these programs is to provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission and to establish appropriately sized observation units (either a dedicated unit or scattered-bed approach) in all hospitals in the county to reduce short stay admissions, thereby minimizing Potentially Preventable Readmissions.

Program Goals

- Procedures reflect implementation of a 30 day transition of care period for high risk inpatient and observation (OBS) patients at participating Suffolk Care Collaborative (SCC) hospitals
- Care Transition Plan is standardized for the SCC and includes the following minimum requirements: follow up appointments, patient self-education, and medication reconciliation

Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must be provided

Integration of Primary Care and Behavioral Health Program

The purpose of this project improve identification and access to Behavioral Health Services in Suffolk County while ensuring those residents who are enrolled in a behavioral health treatment program are receiving primary care services. Over the five-year DSRIP program, the project seeks to implement one of two models at primary care sites across Suffolk County. In addition, the project seeks to implement primary care services at participating Behavioral Health sites including mental health and substance abuse sites.

Program Goals

- Immediate Goal: Improve identification and access to behavioral health services in Suffolk County
    - Model 1) Implement Integrated care by embedding behavioral health specialists into primary care settings and supporting the PCMH model
    - Model 2) Implement Integrated care by embedding primary care services into established behavioral health sites
    - Model 3) Integrate primary care and behavioral health using the IMPACT model, as described in this toolkit

    - In all three models above, care should be as integrated as possible, offering warm handoffs when providers are embedded and coordinated care performed by all members of care team.
- Long Term Goal: Improve identification and access to behavioral health services in Suffolk County

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative

This initiative partners with Hospitals in Suffolk County to implement SBIRT in Hospital Emergency Departments. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.

Program Goals

- Immediate Goal: Implement SBIRT (screening, brief intervention, referral to treatment) protocol in all Suffolk County Hospital Emergency Departments for patients age 13 or older (encouraged for inpatient and observation units as well when a patient is directly admitted without flowing through the ED)
- Long Term Goal: Connect patients with treatment for substance use/ abuse and reduce incidence of substance misuse.

For more information, visit the Suffolk Care Collaborative website at www.suffolkcare.org

Section 2: Screening Tools

New York State

Screening, Brief Intervention, and Referral to Treatment

A Standard of Practice Resulting in Better Health

Governor Andrew M. Cuomo

Commissioner Arlene González-Sánchez, MS, LMSW

Addressing Substance Use for Better Patient Care

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries. Risky substance use is a health issue and often goes undetected.

Why is SBIRT important?

- SBIRT is effective. More than screening, SBIRT is an effective tool for identifying risk behaviors and providing appropriate intervention.
- By screening for high risk behavior, healthcare providers can use evidence-based brief interventions focusing on health and other consequences, preventing future problems.

How does SBIRT work?

- SBIRT incorporates screening for all types of substance use with brief, tailored feedback and advice.
- SBIRT can be performed in a variety of settings. Screening does not have to be performed by a physician.
- Simple feedback on risky behavior can be one of the most important influences on paitient behavior and change.

What are the benefits of SBIRT?

- Prevent disease, accidents and injuries related to substance use, resulting in better patient outcomes.
- SBIRT reduces costly healthcare utilization.
- SBIRT is reimbursable, billing codes are available in New York State.
- Many payers reimburse for SBIRT services.

NYSBIRT is funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA, TI023470).

For more information about SBIRT, including how it can work in your healthcare setting, visit: http://www.oasas.ny.gov/AdMed/sbirt/index.cfm or contact OASAS at SBIRTNY@oasas.ny.gov

New York State
Office of Alcoholism and Substance Abuse Services
Addiction Services for Prevention, Treatment, Recovery
1450 Western Avenue • Albany, NY 12203-3526
518.473.3460 • www.oasas.ny.gov

1-877-8-HOPENY
Find Help for 1-877-846-7369
Alcoholism, Drug Abuse, Problem Gambling

New York State HOPEline
Toll-Free, Anonymous and Confidential
24 hours a day, 365 days a year

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

AUDIT-C - Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:
a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

- **In men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women**, a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.[3]
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

	Men[1]	Women[2]
≥3	Sens: 0.95 / Spec. 0.60	Sens: 0.66 / Spec. 0.94
≥4	Sens: 0.86 / Spec. 0.72	Sens: 0.48 / Spec. 0.99

For identifying patients with active alcohol abuse or dependence

≥ 3	Sens: 0.90 / Spec. 0.45	Sens: 0.80 / Spec. 0.87
≥ 4	Sens: 0.79 / Spec. 0.56	Sens: 0.67 / Spec. 0.94

1. *Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Internal Med. 1998 (3): 1789-1795.*
2. *Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female veterans affairs patient population. Arch Internal Med Vol 163, April 2003: 821-829.*
3. *Frequently Asked Questions guide to using the AUDIT-C can be found via the website: www.oqp.med.va.gov/general/uploads/FAQ%20AUDIT-C*

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

Drug Abuse Screening Test (DAST-10)

Using drugs can affect your health and may interact with medications you take. Please help us provide you with the best medical care by answering the questions below.

Which recreational drugs have you used in the past year?

__Methamphetamines (speed, crystal) __Cocaine

__Cannabis (marijuana, pot) __Narcotics (heroin, oxycodone, methadone)

__Inhalants (paint thinner, aerosol, glue) __Hallucinogens (LSD, mushrooms)

__Tranquilizers (valium) __Other _____

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

I Low Risk/Abstain DAST: 0	II Risky DAST: 1-2	III Harmful DAST: 3-5	IV Dependent DAST: 6+

For Clinician:

Clinician Name:_____ **Date:** _____ **DAST Zone:** _____

Brief intervention:

- ☐ Raised subject
- ☐ Provided feedback
- ☐ Enhanced motivation
- ☐ Negotiated plan
- ☐ Not done
- ☐ Referral recommended

The CRAFFT Screening Questions

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐

"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you answered NO to ALL (A1, A2, A3) answer **only B1** below, then STOP.

If you answered YES to ANY (A1 to A3), answer **B1 to B6** below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:
The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

Pediatric Symptom Checklist - Youth Report (Y-PSC)

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches or pains.....	___	___	___
2. Spend more time alone.....	__	___	___
3. Tire easily, little energy.....	___	___	___
4. Fidgety, unable to sit still.....	___	___	___
5. Have trouble with teacher……	___	___	___
6. Less interested in school.……...	___	___	___
7. Act as if driven by motor.....	___	___	___
8. Daydream too much.....	___	___	___
9. Distract easily.....	___	___	___
10. Are afraid of new situations.....	___	___	___
11. Feel sad, unhappy.....	___	___	___
12. Are irritable, angry.....	___	___	___
13. Feel hopeless.....	___	___	___
14. Have trouble concentrating.....	___	___	___
15. Less interested in friends.....	___	___	___
16. Fight with other children.....	___	___	___
17. Absent from school. …….	___	___	___
18. School grades dropping. ……..	___	___	___
19. Down on yourself.....	___	___	___
20. Visit doctor with doctor finding nothing wrong.....	___	___	___
21. Have trouble sleeping.....	___	___	___
22. Worry a lot.....	___	___	___
23. Want to be with parent more than before.....	___	___	___
24. Feel that you are bad.....	___	___	___
25. Take unnecessary risks.....	___	___	___
26. Get hurt frequently.....	___	___	___
27. Seem to be having less fun.....	___	___	___
28. Act younger than children your age.....	___	___	___
29. Do not listen to rules.....	___	___	___
30. Do not show feelings.....	___	___	___
31. Do not understand other people's feelings.....	___	___	___
32. Tease others.....	___	___	___
33. Blame others for your troubles.....	___	___	___
34. Take things that do not belong to you.....	___	___	___
35. Refuse to share.....	___	___	___

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
	(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
PSC-17 - I ≥ 5
PSC-17 - A ≥ 7
PSC-17 - E ≥7
Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

PSC-17 Scoring

The PSC-17 can help primary care providers assess the likelihood of finding any mental health disorder in their patient. The brief and easy to score PSC-17 has fairly good mental health screening characteristics, even when compared with much longer instruments like the CBCL (Child Behavior Checklist by T. Achenbach).

A 2007 study in primary care offices compared use of the PSC-17 to simultaneous use of the CBCL in 269 children aged 8-15, showing reasonably good performance of its three subscales compared to similar subscales on the CBCL. The gold standard here was a K-SADS diagnosis, which is a standardized psychiatric interview diagnosis. These comparison statistics are summarized below, with positive and negative predictive values shown based on different presumed prevalence (5 or 15%) of the disorders. Providers should notice that despite its good performance relative to longer such measures, it is not a foolproof diagnostic aide. For instance the sensitivity for this scale only ranges from 31% to 73% depending on the disorder in this study:

K-SADS	Screen	Sensitiv-ity	Specific-ity	PPV 5%	PPV 15%	NPV 5%	NPV 15%
ADHD	PSC-17 Attention	0.58	0.91	0.25	0.53	0.98	0.92
	CBCL Attention	0.68	0.90	0.26	0.55	0.98	0.94
Anxiety	PSC-17 Internalizing	0.52	0.74	0.10	0.26	0.97	0.90
	CBCL Internalizing	0.42	0.88	0.13	0.38	0.97	0.90
Depression	PSC-17 Internalizing	0.73	0.74	0.13	0.33	0.98	0.94
	CBCL Internalizing	0.58	0.87	0.19	0.44	0.98	0.92
Externalizing	PSC-17 Externalizing	0.62	0.89	0.23	0.50	0.98	0.93
	CBCL Externalizing	0.46	0.95	0.33	0.62	0.97	0.91
Any Diagnosis	PSC-17 Total	0.42	0.86	0.14	0.35	0.97	0.89
	CBCL Total	0.31	0.96	0.29	0.58	0.96	0.89

W Gardner, A Lucas, DJ Kolko, JV Campo "Comparison of the PSC-17 and Alternative Mental Health Screens in an At-Risk Primary Care Sample" JAACAP 46:5, May 2007, 611-618

PSC-17 Internalizing score positive if ≥ 5
PSC-17 Externalizing score positive if ≥ 7
PSC-17 Attention score positive if ≥7
PSC-17 Total score positive if ≥15

"Attention" diagnoses can include: ADHD, ADD
"Internalizing" diagnoses can include: Any anxiety or mood disorder
"Externalizing" diagnoses can include: Conduct disorder, Oppositional Defiant Disorder, adjustment disorder with disturbed conduct or mixed disturbed mood and conduct

Section 3:
Primary Care & Behavioral Health Integration

Agreement Between
[redacted] and [redacted]

This Agreement (the "Agreement"), dated as of _____, 20[redacted] is by and between [redacted] (the "P.L.L.C."). This Agreement shall commence on _____, 201[redacted] and continue through ____, 201[redacted] (the "Term"), unless previously terminated in accordance with the terms hereof.

It is acknowledged that quality healthcare must focus on both the physical and emotional needs of the patient, within the family and the community. Quality healthcare has at its basis an integration of physical and mental health. Human beings are not just physical bodies with separate minds and emotions. The complex interplay in the attainment of good health recognizes such integration. This is not a new concept. It was noted in the Preamble of the World Health Organization, " Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity".

In furtherance of these principles [redacted] and [redacted] agree to work together to provide increased quality mental health services for children, adolescents and young adults at the [redacted] site located at [redacted]

1. [redacted] hall have the following responsibilities during the Term of this Agreement:

(a) [redacted] shall provide provide case management/care coordination and individual and/or family treatment services related to behavioral issues for patients identified by the [redacted] and other physicians providing services on behalf of the [redacted] as needing such case management/care coordination, individual and/or family counseling services.

(b) [redacted] hall assure all necessary release of information, privacy, and HIPAA forms are executed by all patients receiving its services hereunder and shall communicate with the [redacted] as often as needed to ensure the optimal behavioral and physical health of the patient. Without limiting the foregoing, [redacted] shall comply with applicable HIPAA laws, rules and regulations.

(c) [redacted] shall provide its services hereunder during mutually agreed upon days and times.

(d) [redacted] hall cause its services hereunder to be provided by a licensed social worker and related mental health professionals (collectively, the "Therapists").

(e) [redacted] will make such additional referrals as may be necessary for psychiatric evaluation services required by patients referred by the [redacted] hereunder.

2. [redacted] represents and warrants that the following is true and correct as of the date hereof and shall be true throughout the Term: (i) it is a not-for-profit corporation organized and validly existing under the provisions of New York State law, and (ii) it has all necessary authority and approvals necessary to enter into this Agreement and carry out its obligations hereunder.

3. [redacted] covenants and warrants that, as of the date hereof and throughout the Term, all Therapists shall be licensed to provide social work and related mental health services under New York State law. All Therapists providing services hereunder shall be subject to the prior and continuing approval of the [redacted]

4. [redacted] agrees to indemnify, defend and hold harmless the [redacted] and each of officers, directors, shareholders, members, trustees, employees, contractors, representatives and agents, and each of their heirs, successors and assigns, from any and all claims, suits, actions, losses, damages and costs (including, without limitation, reasonable attorney fees) arising out of the provision of services pursuant to this Agreement (including, without limitation, any arising from its or the Therapists malpractice and its billing and collection activities). The terms of this Section 4 shall survive the termination, expiration or non-renewal of this Agreement.

5. [redacted] shall at all times during the Term obtain and maintain general liability and professional liability (malpractice) insurance coverage (all such insurance shall be with New York State licensed carriers and such malpractice coverage shall provide coverage of at least One Million Three Hundred Thousand Dollars ($1,300,000) per claim and Three Million Nine Hundred Thousand Dollars ($3,900,000) in the annual aggregate) . Such malpractice insurance coverage shall be maintained on an occurrence basis. [redacted] shall cause all such insurance to name the [redacted] as an additional named insured. [redacted] shall provide evidence of such coverage to the [redacted] prior to the date that it commences services hereunder and as may be requested by the [redacted] from time to time.

6. During the Term of this Agreement, the [redacted] shall cause its physicians to make case management/care coordination and individual and/or family counseling for such of its patients as such physicians deem appropriate from time to time. [redacted] recognizes and agrees that nothing herein shall prohibit the [redacted] or such physicians from making such referrals to any other person or entity other than [redacted]

7. The [redacted] agrees to provide [redacted] with office space as it deems to be appropriate at the [redacted] office located at [redacted] to be used by the Therapists during the mutually agreed upon days and times established, to conduct the treatment to be provided hereunder. The parties agree that the services to be provided by [redacted] hereunder are intended to be a pilot project and, accordingly, the [redacted] has agreed not to charge [redacted] any rent for such space during the Term. To the extent that the parties agree that the continuation of such services following the end of the Term is beneficial to each of them and to the [redacted]'s patients, the parties agree that they shall enter into another agreement related to such services which shall include a fair market value rental for the office space provided thereunder by the [redacted] to [redacted]

8. [redacted] will submit invoices to patient's insurance company for reimbursement of services rendered by it hereunder and collect any co-pays directly from the patient.

9. Regardless of whether required by law, [redacted] shall cause its officer(s), director(s), employee(s), servant(s) and/or agent(s) (including, without limitation, the Therapists), to conduct its, his or her activities in connection with this Agreement so as not to endanger or harm any person or property. [redacted] shall deliver services under this Agreement in a professional manner consistent with the best practices of the industry in which such [redacted] operates and in accordance with the applicable rules and regulations of [redacted] shall take all actions reasonably necessary and/or appropriate to meet the obligation described in the immediately preceding sentence, including obtaining and maintaining, and causing all of such Agency's officer(s), director(s), employee(s), servant(s) and/or agent(s) (including, without limitation, the Therapists) to obtain and maintain, all approvals, licenses, and certifications necessary or appropriate in connection with this Agreement and the services to be provided by them hereunder.

10. [redacted] agrees that during the Term and at all times following termination of this Agreement it shall keep strictly confidential all information which it obtains during the Term with respect to the business practices, finances, customers, patients, affairs, trade secrets or otherwise of the P.C., which is not generally known to the public and not use or disclose the same to any other person, firm or corporation except as may be required by law.

If any court or tribunal of competent jurisdiction determines that the duration or any other aspect of the provisions of this Section 10 are unenforceable in accordance with their terms in a particular jurisdiction, the provisions of this Section 10 shall not terminate, but shall be deemed amended to the minimum extent required to render them valid and enforceable in such jurisdiction and such court or tribunal is hereby authorized and directed to amend this Agreement only to the minimum extent necessary to make it valid and enforceable to the maximum extent permitted by law in said jurisdiction.

The provisions of this Section 10 shall survive termination of this Agreement

11. This Agreement may be terminated by either party, with or without cause, by the provision of thirty (30) days written notice to the other party.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth hereinabove.

[redacted]

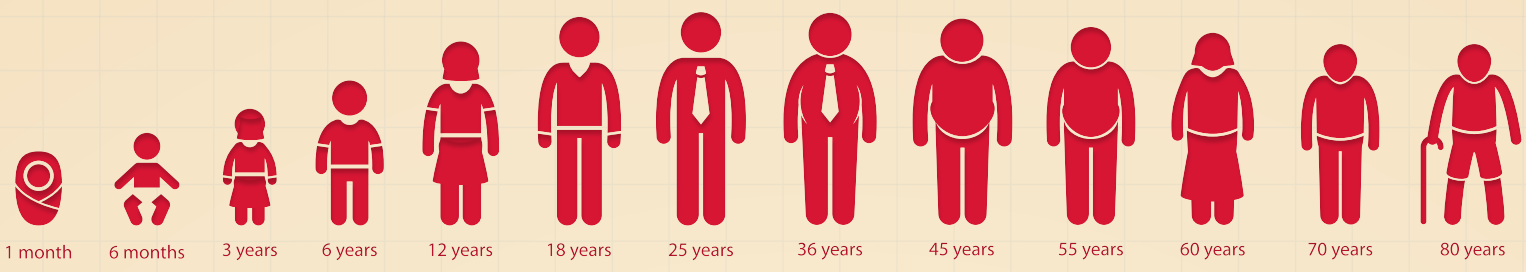
By:_____
Name:
Title:
Date:

[redacted]

By:_____
Name:
Title:
Date:

CAN WE LIVE LONGER?

Integrated Healthcare's Promise



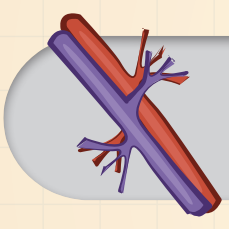
The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

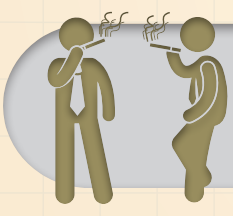
68% of adults with a mental illness have one or more chronic physical conditions

more than **1 in 5** adults with mental illness have a co-occurring substance use disorder

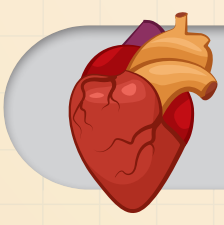
Co-occurrence between mental illness and other chronic health conditions:



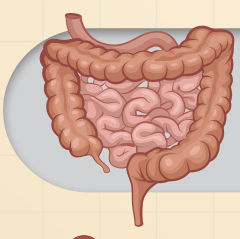
	Mental Illness	No Mental Illness
High Blood Pressure	21.9%	18.8%



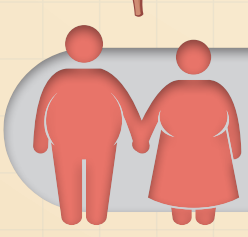
	Mental Illness	No Mental Illness
Smoking	36%	21%



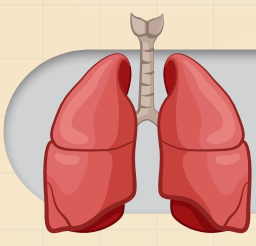
	Mental Illness	No Mental Illness
Heart Disease	5.9%	4.2%



	Mental Illness	No Mental Illness
Diabetes	7.9%	6.6%

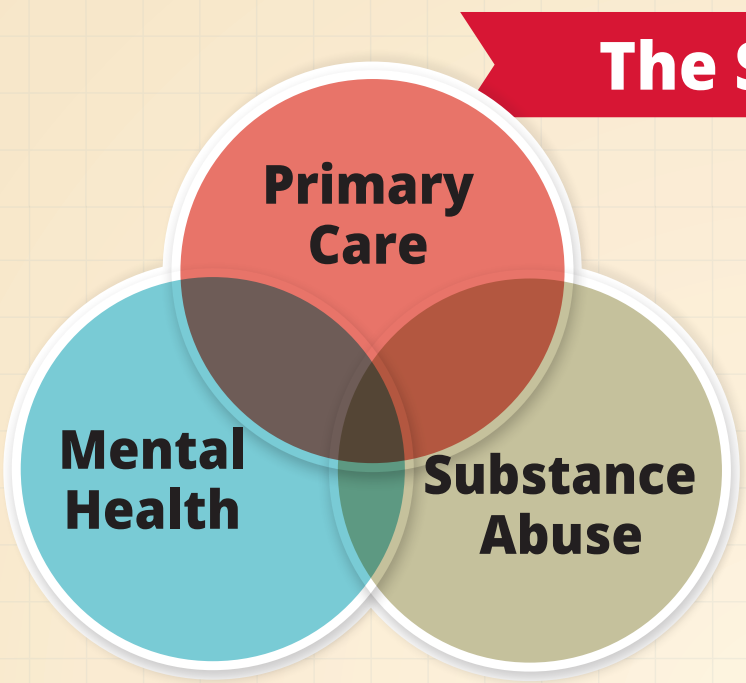


	Mental Illness	No Mental Illness
Obesity	42%	35%



	Mental Illness	No Mental Illness
Asthma	15.7%	10.6%

The SOLUTION



The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.

Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

INTEGRATION WORKS

Community-based addiction treatment can lead to...

- **35%** in inpatient costs
- **39%** in ER cost
- **26%** in total medical cost

Reduce Risk ➡ Reduce Heart Disease
(for people with mental illnesses)

Maintenance of ideal body weight (BMI = 18.5 – 25)	=	35%-55% decrease in risk of cardiovascular disease
Maintenance of active lifestyle (~30 min walk daily)	=	35%-55% decrease in risk of cardiovascular disease
Quit Smoking	=	50% decrease in risk of cardiovascular disease

One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:

This is **$213,000** of savings per month.

That's **$2,500,000** in savings over the year.

Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.

SAMHSA-HRSA
Center for Integrated Health Solutions

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

www.integration.samhsa.gov

Who Do You Know? 1 in 5 PEOPLE HAVE A MENTAL ILLNESS OR ADDICTION

Sources

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www.samhsa.gov/data/2k11/WEB_SR_078/SR110StateSMIAMI2012.htm
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www.samhsa.gov/data/nsduh/2k8nsduh/2k8results.pdf
www.cdc.gov/features/vitalsigns/SmokingAndMentalIllness
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Weisner C. Cost Studies at Northern California Kaiser Permanente. Presentation to County Alcohol & Drug Program Administrators Association of California Sacramento, California. Jan. 28, 2010.

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Hennekens CH, Increasing burden of cardiovascular disease: current knowledge and future directions for research on risk factors. Circulation. 1998;97:1095-1102.

Heritage Behavioral Health Center, based on data in...
www.ahrq.gov/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf

* A grantee of the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration program.

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)

Characteristic	Levels			
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services **1**	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist **2 3 4**	. . are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services **5 6 7**	. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. **8 9 10**
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) 2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)	. . . are not done (in this site) **1**	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care **8 9 10**
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

5. Patient/family involvement in care plan	. . . does not occur **1**	. . . is passive; clinician or educator directs care with occasional patient/family input **2 3 4**	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) **5 6 7**	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources **8 9 10**

6. Communication with patients about integrated care	. . . does not occur **1**	. . . occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style **2 3 4**	. . . occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent **5 6 7**	. . .is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in *how* to communicate with patients about integrated care **8 9 10**
7. Follow-up of assessments, tests, treatment, referrals and other services	. . . is done at the initiative of the patient/family members **1**	. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up **2 3 4**	. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments **5 6 7**	. . . is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments **8 9 10**
8. Social support (for patients to implement recommended treatment)	. . . is not addressed **1**	. . . is discussed in general terms, not based on an assessment of patient's individual needs or resources **2 3 4**	. . . is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs **5 6 7**	. . . is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources **8 9 10**

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

9. Linking to Community Resources	. . . does not occur **1**	. . . is limited to a list or pamphlet of contact information for relevant resources **2 3 4**	. . . occurs through a referral system; staff member discusses patient needs, barriers and appropriate resources before making referral **5 6 7**	. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients **8 9 10**

MeHAF Plus Items				
10. Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications	… does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert **8 9 10**
11. Tracking of vulnerable patient groups that require additional monitoring and intervention	… does not occur **1**	… is passive; clinician may track individual patients based on circumstances **2 3 4**	… patient lists exist and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking **5 6 7**	… patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team **8 9 10**

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

MeHAF Plus Items				
12. Accessibility and efficiency of behavioral health practitioners	… behavioral health practitioner(s) are not readily available **1**	… is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear how much population penetration behavioral health has into primary care population **2 3 4**	… is partially present; behavioral health practitioners may be available for warm handoffs for some of the open clinic hours and may average less than 6 patients per clinic day per clinician (or comparable number based on clinic volume) **5 6 7**	… is fully present; behavioral health practitioners are available for warm handoffs at all open clinic hours and average over 6 patients per clinic day per clinician (or comparable number based on clinic volume) **8 9 10**

II. Practice/Organization (Circle one NUMBER for each characteristic)

Characteristic	Levels			
1. Organizational leadership for integrated care	. . . does not exist or shows little interest **1**	. . . is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care **2 3 4**	. . . is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings) **5 6 7**	. . . strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models **8 9 10**
2. Patient care team for implementing integrated care	. . . does not exist **1**	. . . exists but has little cohesiveness among team members; not central to care delivery **2 3 4**	. . . is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills **5 6 7**	. . . is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled **8 9 10**
3. Providers' engagement with integrated care ("buy-in")	. . . is minimal 1	. . . engaged some of the time, but some providers not enthusiastic about integrated care 2 3 4	. . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components 5 6 7	. . . all or nearly all providers are enthusiastically implementing all components of your site's integrated care 8 9 10
4. Continuity of care between primary care and behavioral/mental health	. . . does not exist	. . . is not always assured; patients with multiple needs are responsible for their own coordination and follow-up	. . . is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only	. . . systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

	1	2 3 4	5 6 7	8 9 10
5. Coordination of referrals and specialists	. . . does not exist **1**	. . . is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team **2 3 4**	. . . occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care **5 6 7**	. . . is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement **8 9 10**
6. Data systems/patient records	. . . are based on paper records only; separate records used by each provider **1**	. . . are shared among providers on an *ad hoc* basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps **2 3 4**	. . . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals **5 6 7**	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process **8 9 10**
7. Patient/family input to integration management	. . . does not occur **1**	. . . occurs on an *ad hoc* basis; not promoted systematically; patients must take initiative to make suggestions **2 3 4**	. . . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consider-ation; patients/families are made aware of mechanism for input and encouraged to participate **5 6 7**	. . . is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information **8 9 10**
8. Physician, team and staff education and training for integrated care	. . . does not occur **1**	. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic **2 3 4**	. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation **5 6 7**	. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration **8 9 10**

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

9. Funding sources/resources	. . . a single grant or funding source; no shared resource streams **1**	. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies **2 3 4**	. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training **5 6 7**	. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly **8 9 10**

Instructions for Completing the MeHAF Site Self Assessment (SSA) Survey – Bidirectional

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site's current extent of integration for patient and family-centered primary care, behavioral and mental health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA.

Please respond in terms of your site's current status on each dimension. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff.

Using the 1-10 scale in each row, circle (or mark in a color or bold, if completing electronically) one numeric rating for each of the 18 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.

This form was adapted from similar formats used to assess primary care for chronic diseases.

Identifying Information:

Name of your site:_____ Date:_____

Name of person completing the SSA form:_____Your job role:_____

Did you discuss these ratings with other members of your team? YES NO

Grantee Organization: _____

I. Integrated Services and Patient and Family-Centeredness				**(Circle one NUMBER for each characteristic)**
Characteristic	**Levels**			
1. Level of integration: primary care and mental/behavioral health care	. . . none; consumers go to separate sites for services **1**	. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist **2 3 4**	. . are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services **5 6 7**	. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings. **8 9 10**
2. Screening and assessment for medical care needs.	. . . are not done (in this site) **1**	. . .are occasionally done; screening/assessment protocols are not standardized or are nonexistent **2 3 4**	. . .are integrated into care on a pilot basis; assessment results are documented prior to treatment **5 6 7**	. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented. **8 9 10**
3. Treatment plan(s) for primary care *and* behavioral/mental health care	. . . do not exist **1**	. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs **2 3 4**	. . .Providers have separate plans, but work in consultation; needs for specialty care are served separately **5 6 7**	. . . are integrated and accessible to all providers and care managers; patients with high or severe medical needs have specialty services that are coordinated with their behavioral health care. **8 9 10**
4. Patient care that is based on (or informed by) best practice evidence for behavioral/mental *and* primary care	. . . does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2 3 4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5 6 7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently **8 9 10**

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

5. Patient/family involvement in care plan	. . . does not occur **1**	. . . is passive; clinician or educator directs care with occasional patient/family input **2** **3** **4**	. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with *some* patients/families and their provider(s) **5** **6** **7**	. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources **8** **9** **10**
6. Communication with patients about integrated care	. . . does not occur **1**	. . . occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style **2** **3** **4**	. . . occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent **5** **6** **7**	. . .is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in *how* to communicate with patients about integrated care **8** **9** **10**
7. Follow-up of medical and behavioral health assessments, tests, treatment, referrals and other services	. . . is done at the initiative of the patient/family members **1**	. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up **2** **3** **4**	. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments **5** **6** **7**	. . . is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments **8** **9** **10**
8. Social support (for patients to implement recommended treatment)	. . . is not addressed **1**	. . . is discussed in general terms, not based on an assessment of patient's individual needs or resources **2** **3** **4**	. . . is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs **5** **6** **7**	. . . is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources **8** **9** **10**
9. Linking to community resources for biopsychosocial needs	. . . does not occur **1**	. . . is limited to a list or pamphlet of contact information for relevant resources **2** **3** **4**	. . . occurs through a referral system; staff member discusses patient needs, barriers, and appropriate resources before making referral **5** **6** **7**	. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients **8** **9** **10**

MeHAF Plus Items					
10. Patient care that is based on (or informed by) best practice evidence for prescribing of both medical and psychotropic medications	… does not exist in a systematic way **1**	. . . depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases **2** **3** **4**	. . .evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers **5** **6** **7**	. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert **8** **9** **10**
11. Tracking of vulnerable patient groups that require additional monitoring and intervention for biopsychosocial health	… does not occur **1**	… is passive; clinician may track individual patients based on circumstances **2** **3** **4**	… patient lists exist and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking **5** **6** **7**	… patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team **8** **9** **10**
12. Accessibility and efficiency of medical providers	… medical providers are not readily available **1**	… is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear how much population penetration primary care has into the behavioral health population **2** **3** **4**	… is partially present; medical providers may be available for warm handoffs for some of the open clinic hours and may average less than 6 patients per clinic day per clinician (or comparable number based on clinic volume) **5** **6** **7**	… is fully present; medical providers are available for warm handoffs at all open clinic hours and average over 6 patients per clinic day per clinician (or comparable number based on clinic volume) **8** **9** **10**

II. Practice/Organization	**(Circle one NUMBER for each characteristic)**			
Characteristic	**Levels**			
1. Organizational leadership for integrated care	. . . does not exist or shows little interest **1**	. . . is supportive in a general way, but views this initiative as a "special project" rather than a change in usual care **2** **3** **4**	. . . is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings) **5** **6** **7**	. . . strongly supports care integration as a part of the site's expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models **8** **9** **10**
2. Patient care team for implementing integrated care	. . . does not exist **1**	. . . exists but has little cohesiveness among team members; not central to care delivery **2** **3** **4**	. . . is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills **5** **6** **7**	. . . is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled **8** **9** **10**
3. Providers' engagement with integrated care ("buy-in")	. . . is minimal **1**	. . . engaged some of the time, but some providers not enthusiastic about integrated care **2** **3** **4**	. . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components **5** **6** **7**	. . . all or nearly all providers are enthusiastically implementing all components of your site's integrated care **8** **9** **10**
4. Continuity of care between primary care and behavioral/mental health	. . . does not exist **1**	. . . is not always assured; patients with multiple needs are responsible for their own coordination and follow- up **2** **3** **4**	. . is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only **5** **6** **7**	. . . systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained **8** **9** **10**

5. Coordination of referrals and specialists for medical and behavioral health needs	. . . does not exist **1**	. . . is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team **2** **3** **4**	. . . occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care **5** **6** **7**	. . . is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care and behavioral health team training and quality improvement **8** **9** **10**
6. Data systems/patient records	. . . are based on paper records only; separate records used by each provider **1**	. . . are shared among providers on an *ad hoc* basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps **2** **3** **4**	. . . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals **5** **6** **7**	. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process **8** **9** **10**
7. Patient/family input to integration management	. . . does not occur **1**	. . . occurs on an *ad hoc* basis; not promoted systematically; patients must take initiative to make suggestions **2** **3** **4**	. . . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate **5** **6** **7**	. . . is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information **8** **9** **10**
8. Physician, team and staff education and training for integrated care	. . . does not occur **1**	. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic **2** **3** **4**	. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation **5** **6** **7**	. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration **8** **9** **10**

Adapted from the PCRS – Developed by the Robert Wood Johnson Foundation Diabetes Initiative, www.diabetesintiative.org; Also adapted from the ACIC survey developed by the MacColl Institute for Healthcare Innovation, Group Health Cooperative.

9. Funding sources/resources	. . . a single grant or funding source; no shared resource streams		. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies			. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training			. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly
	1		**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Section 4: Peers

NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

Peer Support Services in Outpatient Clinical Settings

Background

OASAS recognizes that Substance Use Disorder (SUD) is a chronic illness/condition and as with other chronic, relapsing conditions, individuals seeking to enter long term recovery need a broad continuum of care services including non-clinical support. OASAS has been engaging in system transformation work to expand the availability of a continuum of supports in the process of creating a Recovery Oriented System of Care (ROSC).

ROSC is a coordinated network of community based services and supports that is person-centered and builds on the strengths and resiliency of individuals families and communities to support recovery and improve health, wellness, and quality of life to those with and at risk of substance use disorder. Peer Support Services are a large part of NYS' transformation.

Peer Support Services

A peer is someone with lived experience with substance use who uses their experiential knowledge to support the recovery goals of individuals who use drugs and/or alcohol. Peers are natural support experts, meaning that the relationships they establish can lead to increased feelings of support, safety, and wellbeing among the individuals they serve. Through a combination of lived experience and professional training, peers can provide an array of services to treatment program participants including but not limited to:

- Developing recovery plans
- Raising awareness of existing social and other support services
- Modeling coping skills
- Assisting with applying for benefits
- Accompanying clients to medical appointment
- Providing non-clinical crisis support, especially after periods of hospitalization or incarceration
- Accompanying clients to court appearances and other appointments
- Working with participants to identify strengths
- Linking participants to formal recovery supports
- Educating program participants about various modes of recovery
- Travel training – to use public transportation independently

Peer support services are participant-centered; even though services emphasize knowledge and wisdom through lived experience, peers are encouraged to be extremely intentional in how they share their story or pull from first-hand knowledge to ensure that support work chiefly benefits program participants.

Peer support services are not:

- A program model
- Focused on diagnoses or deficits,

- Helping in a hierarchical way (i.e., there is equal power distribution between Peer and client)
- Treatment compliance
- Medication compliance monitoring
- Monitoring individual behavior
- Care coordination or care management

Role Delineation in Clinical Outpatient Settings

Peers may work in a variety of settings. However, this guidance is focused primarily on the use of peers in clinical outpatient settings and therefore is focused on peers who are Certified Recovery Peer Advocates (CRPA). Peer roles are non-clinical and are an important part of the overall care team, complementing the work of clinicians and better integrating clinical treatment into the larger continuum of care to support the long-term recovery of those impacted by substance use. Peers in a clinical setting must be supervised by a QHP and the supervisor must be oriented to the scope of practice of peers to supervise them properly and assist with their integration into the care team.

In order to fully integrate peers into clinical settings, the clinical team should learn about the role of the peer and clearly understand how it differs from a clinical role. Peers will participate on the multidisciplinary team and may add valuable experience and insight from the perspective of a peer. The role is not a "junior clinician" but as a valuable independent member of the team who offers the unique insight from the point of view of a peer with shared experience. Peers may provide a voice for individuals in treatment as advocates for patient driven goals and objectives. They may also provide solutions to improve recovery orientation of the clinic and in developing richer recovery supports for individual patients and develop recovery resources for the clinic.

Peer Certification

Peers working in OASAS licensed and HCBS designated programs need to be Certified Recovery Peer Advocates (CPRA). To become an OASAS Certified Recovery Peer Advocate, an individual must have 46 hours of required training, (advocacy, mentoring and education, recovery and wellness, and ethical responsibility). They must hold a high school diploma or have their GED and pass the International Certification and Reciprocity Consortium (IC-RC) exam. Certification also requires 500 hours of related volunteer or work experience and 25 hours of supervision by qualified supervisory staff. At this time, the OASAS-approved certification entities that can provide this certification are the New York Certification Board and the New York Certification Association.

Provisional Peer Certification

Provisional certification allows a program to hire a provisional CRPA and to bill Medicaid for peer support services provided by a provisional CRPA. An individual can obtain a provisional CRPA (CRPA-P) providing they have completed the required CRPA training and has submitted an application

to one of the certification entities but has not competed the total number of required work experience work hours. The provisional CRPA has 24 months to obtain their 500 hours of work experience by working in an OASAS Certified Program.

Documentation Requirements

Individuals may receive Peer Support Services in an 822-regulated program through either active enrollment or a continuing care plan (see continuing care guidance). They may also receive peer services from a Home and Community Based Service (HCBS) program if they are eligible for HCBS through HARP (Health and Recovery Plans). Individuals receiving 822 outpatient treatment may not receive HCBS Empowerment Peer Support, if they are receiving peer support at the outpatient program

For 822 Regulated programs:

The clinician should identify in the client treatment plan the clinical reason(s) for peer support services, the progress towards the specific goal, and follow up or next steps. The peer should provide a note for each visit, the duration and the overall purpose of the service. For example, see the samples below for treatment plan goals and in the Resource Section for documents related to examples.

Sample Documentation

- Goal: Matthew is in the intermediate stages of treatment and wishes to re-engage with his natural community supports in anticipation of program completion and discharge. Plan: Matthew will meet with George, the program's peer advocate for three sessions to develop a recovery plan and identify resources in the community to support his ongoing recovery post treatment.
- Goal: Sheila is in the early stages of recovery and would benefit from peer support to enhance her motivation to remain in treatment and begin to build her support network. Plan: Sheila will meet with George for three sessions to develop her recovery plan and identify community supports to enhance her coping strategies.
- Goal: John has successfully completed treatment and wishes to continue his connection with peer services in the community. Plan: John will meet monthly with a peer to make connections that will help him to maintain the gains he has made in treatment, and to expand his knowledge of recovery capital in the community.
- Goal: Cheryl has returned to the program after being absent for three weeks and has been assessed to have an opioid use disorder and has agreed to a medical assessment for medication assisted treatment. Plan: George will accompany Cheryl to Dr. Smith's office to offer support during Dr. Smith's evaluation.

Services in a Part 822 - Certified Clinic

The format for billing and reimbursement is the same as it was under the previous Fee-for-Service model in New York City. Peer support is a face to face service and is coded as a procedure-based weight that recognizes units. Each unit is 15 minutes, and only 4 units can be coded per visit date (equaling an hour maximum of peer services). Peer support services are exempt from the 2 billable services per day rule (*). The HCPCS procedure code is H0038 and the description category is Self-Help/Peer Services. The payment rate is given as follows:

FREESTANDING	**822 Clinic Upstate**	**822 Clinic Downstate**	**822 Opioid Upstate**	**822 Opioid Downstate**
Peer Counseling	$11.15 per 15 minute unit	$13.05 per 15 minute unit	$10.28 per 15 minute unit	$12.03 per 15 minute unit
HOSPITAL BASED	**822 Clinic Upstate**	**822 Clinic Downstate**	**822 Opioid Upstate**	**822 Opioid Downstate**
Peer Counseling	$11.08 per 15 minute unit	$13.87 per 15 minute unit	$11.88 per 15 minute unit	$13.87 per 15 minute unit

**Typically, a provider can only bill Medicaid for two services per visit date. Peer services are exempt from this protocol.*

Resources

Hendry, P., Hill, T., Rosenthal, H. Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. ACMHA: The College for Behavioral Health Leadership and Optum, 2014
http://www.consumerstar.org/site/sites/default/files/documents/Peer_Services_Toolkit.pdf

Morris, C., Banning, L, Mumby, S., Morris, C. Dimensions Peer Support Program Toolkit, University of Colorado Anschutz Medical Campus School of Medicine, Behavioral Health and Wellness Program, June 2015
https://www.bhwellness.org/toolkits/Peer-Support-Program-Toolkit.pdf

APG Billing and Policy Guide
https://www.oasas.ny.gov/admin/hcf/APG/documents/APGManual.pdf

New York Certification Association
http://nycertification.org/

New York Certification Board
http://www.asapnys.org/ny-certification-board/

NY Alliance for Careers in Healthcare
www.nyachnyc.org

Continuing Care Guidance document
http://www.oasas.ny.gov/ManCare/documents/ContinuingCareGuidance.pdf

OASAS Part 822 Services in the Community Billing Document
http://www.oasas.ny.gov/ManCare/documents/ServicesintheCommunity.pdf

ROSC Resource Guide
www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

NY – Friend of Recovery NY website
https://www.for-ny.org

National Alliance for Medication Assisted Recovery (NAMA-R)
www.methadone.org

William White Resource Papers
www.williamwhitepapers.com

HCBS Manual
https://www.omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf

Section 5: Billing

State: New York, July 2014

CPT Code		Diagnostic Code	Community Health Center					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt 99211 - 99215 Est. Pt.	May be used for behavioral health or physical health services	Yes	MD, PA, ANP	Yes	99201-99205 New Pt 99211 - 99215 Est. Pt.	MD, PA, ANP	
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	Yes	96150 Assessment	Non-physician mental Health practitioners	
	96151 Reassessment		Yes			96151 Reassessment		
	96152 Individual TX		Yes			96152 Individual TX		
	96153 Group TX		Yes			96153 Group TX		
	96154 Family TX w/ PT		Yes			96154 Family TX w/ PT		
	96155 Family TX w/o PT		No			96155 Family TX w/o PT		
Tele-medicine	90791 GT Psych eval w/o medical services	Psychiatric diagnosis	Yes	Physician, NP, PA, CNS, Clinical Psychologist, Clinical Social Worker	Yes	90791 GT Psych eval w/o medical services	Psychiatrist, Clinical Psychologist	Hub and Spoke Eligible sites: Article 28 hospitals, Diagnostic & Treatment Centers, FQHC's that have opted into APG's. The patient must be physically present at the originating "spoke" site; the physician specialist and/or CDE/CAE is located at the "hub" site. The physician specialist at the "hub" site, who is performing the consult, must be licensed in New York State, enrolled in New York State Medicaid and be credentialed and privileged at both the "hub" and "spoke" site hospital and/or D&TC.
	90792 Psych eval w/ medical services			Physician, NP, PA, CNS		90792 Psych eval w/ medical services	Psychiatrist	
	90832-38 GT Therapy Services			Psychiatrist, CNP, Clinical Psychologist, Clinical Social Worker	Yes	90832-38 GT Therapy Services	Physician, NP, PA, Nurse-Midwife, CNS, Psychologist, Clinical Social Worker	
	99201-99215 Office or other OP services	Both MH & PH diagnosis	Yes	Physician, NP, PA, CNS	Yes	99201-99215 GT Office or other OP services	Physician,	
Alcohol & Substance Services	96150-54 HABI Codes	Physical health diagnosis	No	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	No			
	G0459 GT Pharmacological Management				No			
	G0406-G0408 GT Inpatient Consultation		Yes					
	G0442 GT Annual Alcohol Misuse Screen	1 per year	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	No			
	G0443 GT Brief Face to Face Counseling for alcohol misuse	4- 15 minute interventions within the 11			No			
	G0444 Annual			Physician, Nurse				

Health, Obesity and Tobacco Counseling (Face to Face & Telemedicine	Depression Screening	Use GT for Telemedicine;	See Behavioral Health section	Physician, Nurse, PA	No			
	G0108, G0109 Ind-Group Diabetes Tx			Physician or certified provider				
	G0447 Behavioral Counseling for Obesity			Physician, NP, PA				
	G0436-37, 99406-07 Smoking Cessation			Physician, NP, PA				
	G0446 Behavioral Counseling for cardiovascular			Physician, Clinical Nurse Specialist, Certified Nurse-				
Substance Use Codes / SBIRT	G0442 Annual Alcohol Misuse Screen	1 per year	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	Yes	H0001 - AOD Assessment		
	G0443 Brief Face to Face Counseling for alcohol misuse	4- 15 minute interventions within the 11 months after a positive screening				H0002 BH Screen H0004 BH Counseling H0005 AOD Group		
Mental Health	90791 Psych eval w/o medical services	Use with BH diagnosis codes	Billable in and by primary care clinics - check your state's FQHC manual for billability in your state.	Physician, NP, PA, CNS	Yes	90791 Psych eval w/o medical services	Psychiatrist, PA, APRN, Clinical Psychologist, LCSW	
	90792 Psych eval w/ medical services					90792 Psych eval w/ medical services	Psychiatrist, PA, APRN, Clinical Psychologist	
	90832-38 Therapy Services			Physician, NP, PA, CNS, Psychologist, LCSW		90832-38 Therapy Services	Psychiatrist, PA, APRN, Clinical Psychologist, LCSW	
	H0031 Mental Health Assessment				No			
	90863 Group Therapy							
	H2011 Crisis Intervention							
	T1017 Case Management		No					
Two services in one day billable at FQHC?				**Yes**				
there can be 2 encounters for different types of visits on the same day (ex: physician and social worker)								

SBIRT	Yes -with Medicare and specific providers w/ grants

CPT Code		Diagnostic Code	Community Mental Health Centers (CMH)					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt	May be used for behavioral health or physical health services	Yes	MD, PA, ANP	Yes	99201-99205 New Pt	MD, PA, Certified NP	
	99211 - 99215 Est. Pt.					99211 - 99215 Est. Pt.		

Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	No			
	96151 Reassessment		Yes					
	96152 Individual TX		Yes					
	96153 Group TX		Yes					
	96154 Family TX w/ PT		Yes					
	96155 Family TX w/o PT		No					
Tele-medicine	90791 GT Psych eval w/o medical services	Psychiatric diagnosis	Yes	Psychiatrist, CNP, Clinical Psychologist,	Yes	90791 GT Psych eval w/o medical services	Psychiatrist	
	90792 GT Psych eval w/ medical services			Psychiatrist, CNP, CNS		90792 GT Psych eval w/ medical services	Psychiatrist	
	90832-38 GT Therapy Services			Psychiatrist, CNP, Clinical Psychologist, Clinical Social Worker	Yes	90832-38 GT Therapy Services	Physician, NP, PA, Nurse-Midwife, CNS, Psychologist, Clinical Social Worker	
	99201-99215 GT Office or other OP services	Both MH & PH diagnosis	Yes	Physician, NP, PA, CNS	Yes	99201-99215 GT Office or other OP services	Psychiatrist, NP, PA	
	96150-54 GT HABI Codes	Physical health diagnosis	No		No			
	G0459 GT Pharmacological Management							
	G0406-G0408 GT Inpatient Consultation		Yes					
Alcohol & Substance Services	G0442 GT Annual Alcohol Misuse Screen	1 per year	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	No			
	G0443 GT Brief Face to Face Counseling for alcohol misuse	4- 15 minute interventions within the 11						
Health, Obesity and Tobacco Counseling (Telemedicine and Face to Face)	G0444 Annual Depression Screening	Codes are reimbursed by Medicare and other insurances in a primary clinic. Use GT for telemedicine	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA, LMSW, LP				
	G0108, G0109 Ind-Group Diabetes Tx							
	G0436-37, 99406-07 Smoking Cessation							
	G0446 Behavioral Counseling for cardiovascular disease							
	G0442 Annual Alcohol Misuse Screen	1 per year in a primary care clinic		Physician,		H0004 AOD Ind Tx H0005 AOD Group	Physicians, NP, LP,	

Substance Use Codes / SBIRT	G0443 Brief Face to Face Counseling for alcohol misuse	4- 15 minute interventions in a primary care clinic within the 11 months after a positive screening	Yes	Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	Yes	H0001 AOD Assessment H0002 BH Screening	LLP, CSW	
Mental Health	90791 Psych eval w/o medical services	Use with BH diagnosis codes	Yes	Physician, NP, PA, CNS	Yes	90791 Psych eval w/o medical services	Psychiatrist, NP	
	90792 Psych eval w/ medical services					90792 Psych eval w/ medical services	Psychiatrist	
	90832-38 Therapy Services			Physician, NP, PA, CNS, Psychologist, LCSW		90832-36, 90853	Clinical Social Worker, NP	Clinical Social Worker can only use 90834 and 90837 90785 - Interactive complexity can be added on
	H0031 Mental Health Assessment							
	90863 Group Therapy							
	H2011 Crisis Intervention							
	T1017 Case Management		No			5250-5259 CSM	Qualifications - Master's or Bachelor's degree in health, human or education services, and one year of qualifying experience; or Associate's degree in health or human services or certification as an	Must be pre-approved for varying levels of case management
	T1016 Supports Coordination							
Peer Support	H0038 Peer Support		No		No	H0038 Peer Services, Ind & Group (HQ), Whole Health & Wellness Coach		
	H0038 Peer Support Group Services							

References:

Medicare Billing Information www.cms.gov

Medicare Telemedicine: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

FQHC Information: https://www.emedny.org/meipass/webinar/EPFQHCMEIPASSWalkthrough.pdf

Telemedicine: https://www.emedny.org/providermanuals/physician/PDFS/Physician_Procedure_Codes_Sect2.pdf

Mental Health Psychiatry / E&M https://www.emedny.org/providermanuals/physician/PDFS/Physician_Procedure_Codes_Sect2.pdf

Mental Health SW: https://www.emedny.org/ProviderManuals/ClinicalSocWork/PDFS/ClinicalSocialWorker_Fee_Schedule.pdf

Mental Health Pscyhologist:https://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM_Billing_Guidelines_UB04.pdf

Mental Health CSM: https://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM_Billing_Guidelines_UB04.pdf

Section 6: Resources

Suffolk County Communities of Solution
Substance Use Disorder (SUD) Treatment Referral List - updated 2/24/17

www.cosresources.wordpress.com

NYS Office of Alcoholism and Substance Abuse Services (NYS OASAS) Hopeline: 1-877-846-7369

*****IN SUFFOLK COUNTY CALL - LICADD 24/7 HOTLINE - 631-979-1700*****

"Don't Stall, Make the Call" – Any number listed below will guide you in the right direction

Location	Detoxification (Withdrawal &	Phone	Age	Legend
Amityville	South Oaks	631 264-4000	18+	* ±@◊
Bohemia	Catholic Charities Talbot House	631 589-4144	18+	* ± @
Greenport	Eastern Long Island Hospital	631 477-8877	18+	* ±@◊
Hampton Bays	Long Island Center For Recovery	631 728-3100	18+	*◊
Port Jefferson	St. Charles Hospital	631 474-6981	18+	* ±@◊
Ronkonkoma	Phoenix Houses of LI, Inc.	631 306-5710	18+	* ±@
Westhampton Beach	Seafield Center	631 288-1122	18+	*◊
	Inpatient			
Amityville	South Oaks	631 264-4000	18+	*±@«×◊
Brentwood	Charles K. Post ATC	631 434-6233	19+	± @ « ×
Greenport	Eastern Long Island Hospital	631 477-8877	18+	* ±@◊
Hampton Bays	Long Island Center For Recovery	631 728-3100	18+	*◊
Pt. Jefferson	St. Charles Hospital	631 474-6233	19+	* ±@◊
Westhampton Beach	Seafield Center	631 288-1122	16+	*◊
	Residential			
Brentwood	Charles K. Post ATC	631 434-7200	18+	± @ « ×
Brentwood	Outreach	631 231-3232	13+	* ±@
Brentwood	Phoenix Houses of LI, Inc.	631 306-5710	18+	* ±@
Dix Hills	SCO Family of Services Morning Star	631 643-0849	18+	± @
Dix Hills	SCO Family of Services Morning Star II	631 643-6663	18+	± @
East Hampton	The Dunes	631 324-3446	18+	◊
Selden	Concern for Independent Living, Inc.	631 758-0474	18+	±@
	Opioid Treatment Programs			
Hauppauge	Suffolk County	631 853-7373	16+	* ± @ «
Riverhead	Suffolk County	631 852-2680	16+	* ± @«
	Substance Use Disorder - Outpatient			
Amityville	Hope for Youth	631 842-7900	12+	±@
Amityville	Seafield Services	631 424-2900	18+	* #@◊
Amityville	South Oaks	631 264-4000	13+	* ±@
Bay Shore	Family Service League	631 647-3100	13+	* ± ~ @
Bellport	Outreach	631 286-0700	13+	* ± ^@ «◊
Bohemia	Institute for Rational Counseling, Inc.	631 567-7760	13+	
Brentwood	Outreach	631 436-6065	18+	* ± ~ @◊
Brentwood	Phoenix House of LI, Inc.	631 306-5740	18+	* ±@ #
Commack	Catholic Charities	631 543-6200	18+	* ± @«◊

Location	Substance Use Disorder- Outpatient (con't)	Phone	Age	Legend
Deer Park	B.E.S.T.	631 392-4357	18+	*◊
East Hampton	The Dunes	631 604-5405	18+	◊
East Hampton	Phoenix House of LI, Inc.	631 329-0373	18+	±@
East Islip	Sanctuary East, Ltd	631 224-7700	13+	±@ ~
Hampton Bays	Catholic Charities	631 723-3362	18+	* ±@ ~
Hampton Bays	Long Island Center For Recovery	631 728-3100	18+	◊
Hauppauge	The Kenneth Peters Center for Recovery	631 273-2221	18+	* # @ «◊
Holtsville	YMCA Family Services	631 580-7777	16+	± ~ @◊
Huntington	Samaritan Village @ Daytop	631 351-7112	13+	* ±@ ~◊«x
Huntington	Huntington Drug & Alcohol	631 271-3591	13+	±@ ~◊
Huntington	PSCH	631 920-8324	15+	* ±@ « ×
Lake Grove	Impact Counseling Services, Inc.	631 467-3182	16+	~◊
Mastic	Family Service League	631 924-3741	13+	* ± ~ @
Medford	Seafield Services	631 451-6007	13+	# ~@◊
North Babylon	Town of Babylon	631 422-7676	12+	*±@ ~«◊
Patchogue	Brookhaven Memorial Hospital	631 854-1222	18+	±@
Patchogue	Seafield Services	631 363-2001	18+	# @
Pt. Jefferson Sta.	John T. Mather Memorial Hospital	631 331-8200	13+	±@ #
Riverhead	Alternatives Counseling Services	631 369-1200	14+	*±@ # ~«◊
Riverhead	Eastern Long Island Hospital	631 369-8966	18+	* ±@ #«
Riverhead	Family Service League	631 369-0104	13+	± ~ @
Riverhead	Maryhaven Center of Hope, Inc.	631 727-0710	12+	* ±@◊
Riverhead	Seafield Services	631 369-7800	14+	# @◊
Ronkonkoma	C.A.R.E.	631 532-5234	18+	*◊
Ronkonkoma	Community Counseling Services	631 471-3122	17+	◊
Shirley	Brookhaven Memorial Hospital	631 852-1070	18+	±@◊
Smithtown	Employee Assistance Resources	631 361-6960	18+	*◊
Smithtown	PSCH	631 920-8324	15+	*±@«×◊
Smithtown	Town of Smithtown Horizons	631 360-7578	12+	*±@«×◊
Southampton	Alternatives Counseling Services	631 283-4440	13+	*±@#~◊«
Wyandanch	PSCH	631 920-8324	15+	*±@«×
	Information/ Intervention Services (non-licensed)			
Holbrook/Riverhead	L.I.C.A.D.D	631 979-1700	13+	◊
	National Suicide Prevention Lifeline	1-800-273-TALK (2855)		
	FIST Families In Support of Treatment	858-367-3478		±
	LIRA Long Island Recovery Association	631 552-5472		±

Legend - (*) Medication Assisted Treatment Programs (±) Non-Profit Treatment Providers (#) Intensive Outpatient Service (~) Spanish Speaking (^) Outpatient Rehabilitation

(@) Pregnant Women («) MAT for Pregnant Women (×) Induction of Pregnant Women (◊) Family

Suffolk County Communities of Solution
Substance Use Disorder (SUD) Treatment Referral List

NYS Attorney General's Health Care Bureau: 1-800-428-9071
NYS Combat Heroin - http://www.combatheroin.ny.gov
"Ability to pay is not a barrier to treatment".
Agencies denoted Non-Profit are required to provide services regardless of ability to pay. All agencies provide a sliding scale.

Treatment Service Descriptions:

Detoxification (Withdrawal and Stabilization Services): withdrawal and stabilization services manage the treatment of alcohol and/or substance withdrawal as well as acute disorders associated with alcohol and/or substance use, resulting in a referral for continued care.

* **Medically Managed Detoxification Service** (hospital setting): Medically managed withdrawal and stabilization services are designed for patients who are acutely ill from alcohol-related and/or substance-related addictions or dependence, including the need for medical management of persons with severe withdrawal or risk of severe withdrawal symptoms.

* **Medically Supervised Withdrawal Services** (hospital or other OASAS certified inpatient or outpatient settings): Medically supervised withdrawal services provide treatment to individuals with moderate withdrawal symptoms and non-acute physical or psychiatric complications coupled with situational crisis, or who are unable to abstain with an absence of past withdrawal complications. Medically supervised outpatient withdrawal and stabilization services are appropriate for persons with above symptoms and have a stable environment.

* **Medically Monitored Withdrawal** (free-standing community based or additional service of a certified inpatient or residential provider): Medically monitored withdrawal services (crisis centers) provide monitoring of mild withdrawal symptoms and uncomplicated withdrawal. The crisis centers also provide services for those in situational crises at risk for relapse.

*** Ancillary Withdrawal Services** (inpatient/outpatient): Ancillary withdrawal services are the medical management of mild or moderate symptoms of withdrawal within an OASAS-certified inpatient/outpatient clinic setting who have a protocol for providing ancillary withdrawal services approved by the OASAS Medical Director.

Medication Assisted Treatment: An OASAS-certified outpatient clinic that in addition to the services above is also certified to prescribe and monitor addiction medications including buprenorphine, naltrexone, alcamprosate, disulfiram, and others.

Outpatient Services: OASAS- certified Outpatient Services provide group and individual counseling; education about, orientation to, and opportunity for participation in, relevant and available self help groups; alcohol and substance abuse disease awareness and relapse prevention; HIV and other communicable disease, education, risk assessment, supportive counseling and referral; and family treatment. Additional services include social and health care services, skill development in accessing community services, activity therapies, information and education about nutritional requirements, and vocational and educational evaluation. Intensive Outpatient Services are also available.

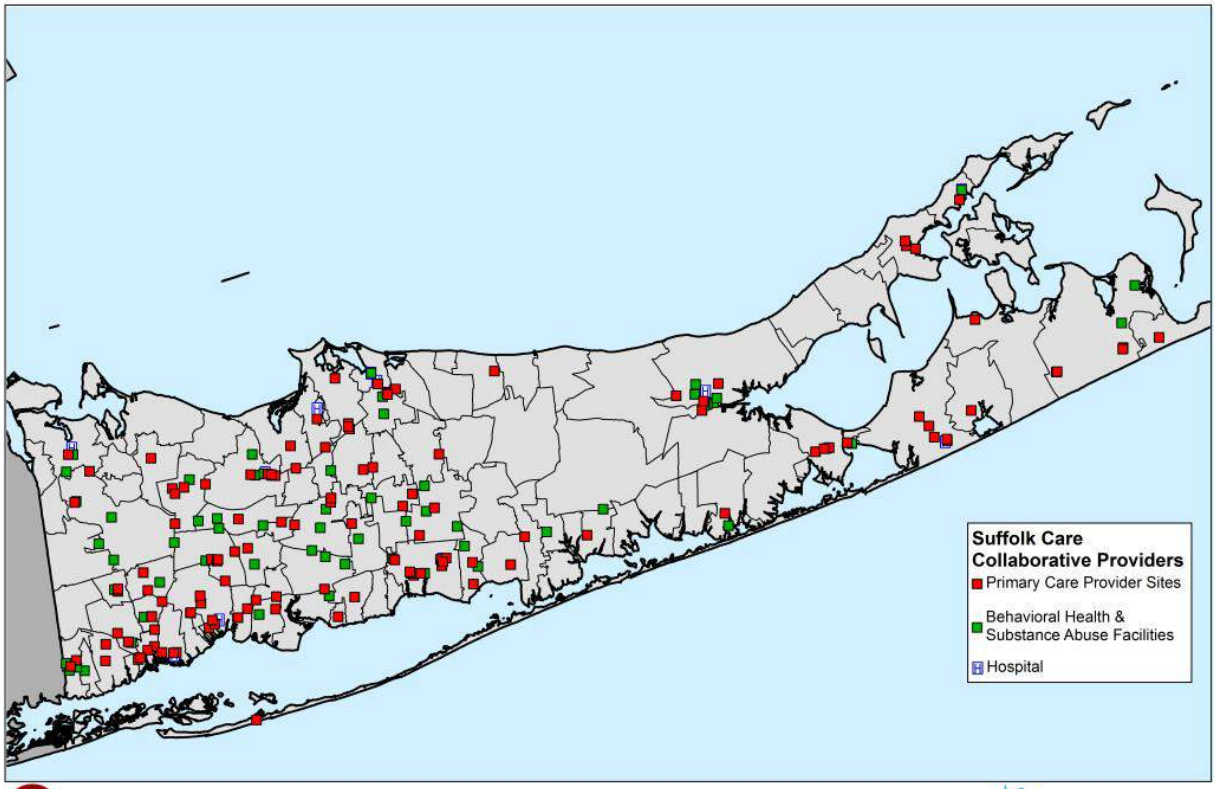
Inpatient: An OASAS-certified treatment with 24- hour medical coverage and oversight provided to individuals with significant acute medical, psychiatric and substance use disorders with significant associated risks. Inpatient rehabilitation services provide intensive management of substance dependence symptoms and medical management/monitoring of medical or psychiatric complications to individuals who cannot be effectively served as outpatients and who are not in need of medical detoxification or acute care.

Residential Rehabilitation Service: This is a treatment setting that provides a 24-hour structured program for those with a chronic substance use disorder.

Outpatient Rehabilitation Services: OASAS-certified services designed to assist individuals with chronic medical and psychiatric conditions. These programs provide: social and health care services; skill development in accessing community services; activity therapies; information and education about nutritional requirements; and vocational and educational evaluation. Individuals initially receive these procedures three to five days a week for at least four hours per day.

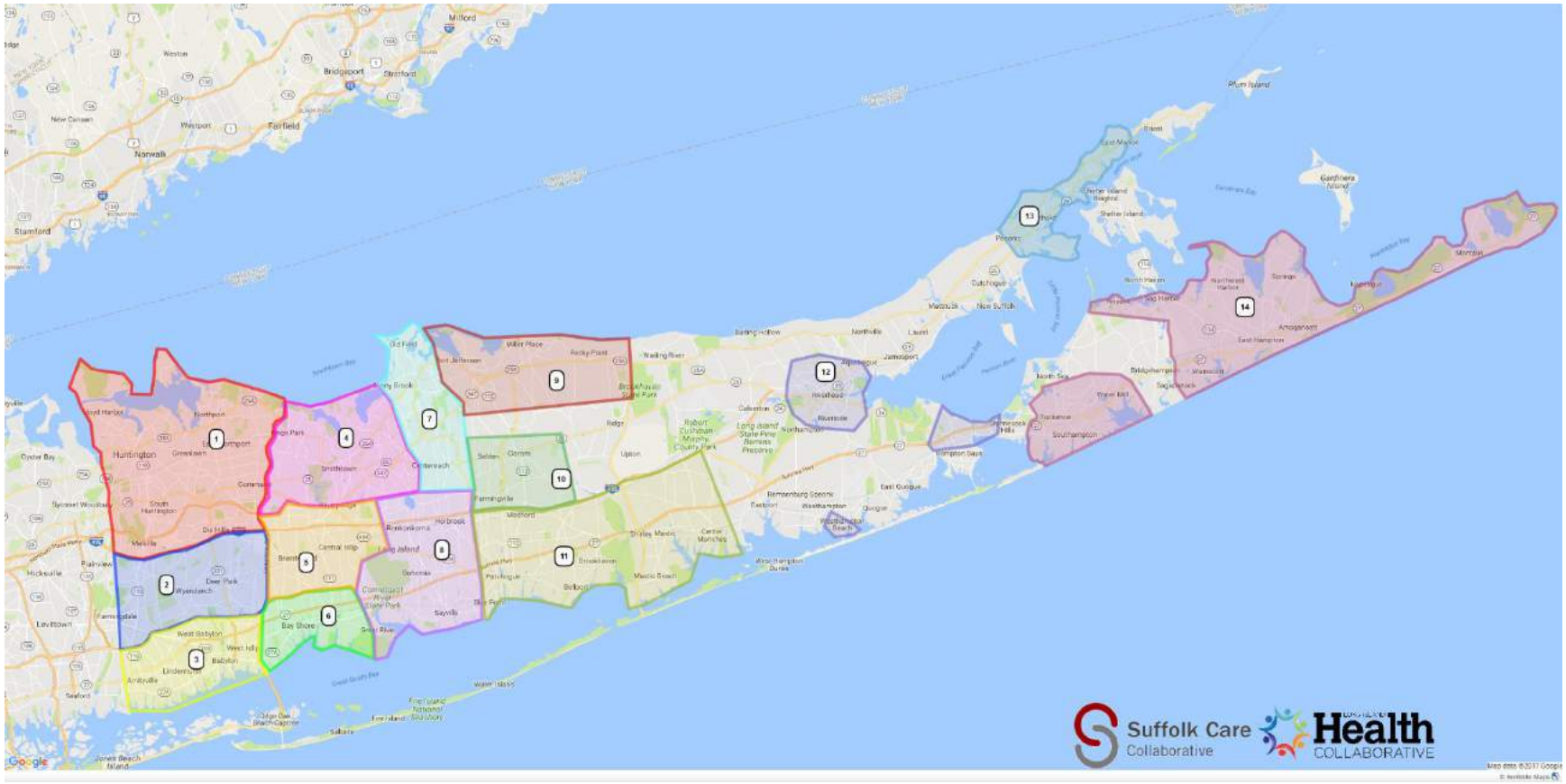
Opioid Treatment Programs: OASAS-certified sites where methadone or other approved medications such as Suboxone® are administered to treat opioid dependency following one or more medical treatment protocols defined by State regulation. OTPs offer rehabilitative assistance including counseling and educational and vocational rehabilitation.

Map of Suffolk Care Collaborative Providers



Suffolk Care
Collaborative

LONG ISLAND
Health
COLLABORATIVE
connecting you to better health


Suffolk Care Collaborative
Health COLLABORATIVE

Region 1 - Huntington Hospital	
MID SUFFOLK ISLAND MEDICAL CARE	PCP
RBK Pediatrics	PCP
Commack Pediatrics Associates	PCP
SUSAN GUNDUZ MD	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
Huntington Village Pediatrics	PCP
Huntington Drug & Alcohol	Behav Health and Substance Abuse
PSCH	Behav Health and Substance Abuse
Huntington Hospital	Hospital
Sagamore Psychiatric Facility	Behav Health and Substance Abuse
Vieytez, Javier F.	PCP
Hampton Bays Chemical Dependence Clinic	Behav Health and Substance Abuse
Samaritan Village @ Daytop	Behav Health and Substance Abuse
Long Island Premier Medical Care	PCP

Region 2 - Huntington Hospital/Good Samaritan Hospital	
SCO Family of Services Morning Star	Behav Health and Substance Abuse
ADVANTAGECARE PHYSICIANS	PCP
Cebelenski, Rosanne	PCP
Lerias, Edgar F. M.D.	PCP
Parasmo, Frank	PCP
B.E.S.T.	Behav Health and Substance Abuse
Federation of Organizations for NYS Mentally Disabled-Wyandanch Clinic	Behav Health and Substance Abuse
SKOPE MEDICAL CARE PC	PCP
Marquis, Belinda A., M.D., P.C.	PCP
PSCH	Behav Health and Substance Abuse
HRH – Martin Luther King Jr. Health Center-Wyndanch	PCP
Buckman Center	Behav Health and Substance Abuse

Region 3 - Good Samaritan Hospital	
Alaaeldin Pediatircs PC	PCP
Apu, Sheena M.D.	PCP
Araceli, Dantes	PCP
Babylon Village Pediatrics	PCP
Balot, Dr. Barry	PCP
Brunswick Hall	Behav Health and Substance Abuse
Divisionof drug Alcohol Services	Behav Health and Substance Abuse
Federation of Organizations for NYS Mentally Disabeled -Recovery Concepts West	Behav Health and Substance Abuse
Federation of Organizations for NYS Mentally Disabled - ACT	Behav Health and Substance Abuse
Federation of Organizations for NYS Mentally Disabled - Recovery Concepts West Babylon	Behav Health and Substance Abuse
Good Samaritan Hospital Medical Center	Hospital
Gutierrez-Lazo, Eleonor	PCP
Health Medical Pc	PCP
Hope for Youth	Behav Health and Substance Abuse
HRH – Maxine S. Postal Tri-Community Health Center-Amityville	PCP
Li Medical Care Services	PCP
LINDENHURST MEDICAL CENTER	PCP
Medihealth Medical Pc	PCP
Newborn and Pediatric Care (Jasone Hitner)	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
PEDIATRIC IMMEDIATE CARE PLLC	PCP
Rajesh Mariwalla, MD, PC	PCP
Seafield Services	Behav Health and Substance Abuse
South Oaks	Behav Health and Substance Abuse
Suffolk Pediatrics Associates PC	PCP
Town of Babylon	Behav Health and Substance Abuse
US MEDICAL PLAZA	PCP

Region 4 - St. Catherine of Siena Medical Center	
Catholic Charities	Behav Health and Substance Abuse
Commack Chemical Dependence Clinic	Behav Health and Substance Abuse

ISLAND HEALTH CARE	PCP
Complete Family Medical Care PLLC	PCP
PEDIATRIC IMMEDIATE CARE PLLC	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
Branch Pediatric & Adolescent Group	PCP
SBU Children's - Smithtown Pediatric Group	PCP
All Inclusive Primary care	PCP
Employee Assistance Resources	Behav Health and Substance Abuse
LISH at Smithtown	Behav Health and Substance Abuse
PSCH	Behav Health and Substance Abuse
Town of Smithtown Horizons	Behav Health and Substance Abuse
St. Catherine of Siena Medical Center	Hospital
Impact Counseling Services, Inc.	Behav Health and Substance Abuse

Region 5 - St. Catherine of Siena Medical Center/Southside Hospital	
Quality Medical Care For Entire Family (Qureshi)	PCP
Outreach Islip	Behav Health and Substance Abuse
C. K. Post Addiction Treatment Center	Behav Health and Substance Abuse
Federation of Organizations for NYS Mentally Disabled - Care Coordination Multiple Adult Homes	Behav Health and Substance Abuse
SUFFOLK FIRST MEDICAL, PC	PCP
Bruce H Platnik MD	PCP
HRH - Brentwood	PCP
Charles K. Post ATC	Behav Health and Substance Abuse
Phoenix House of LI, Inc.	Behav Health and Substance Abuse
Suffolk Pediatrics	PCP
LISH at Central Islip	Behav Health and Substance Abuse
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
C.A.R.E.	Behav Health and Substance Abuse
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
SUFFOLK FIRST MEDICAL, PC	PCP
DOC CARE	PCP
LISH at the Family Wellness Center	Behav Health and Substance Abuse
Suffolk County	Behav Health and Substance Abuse
The Kenneth Peters Center for Recovery	Behav Health and Substance Abuse
Long Island Pediatrics Of Brentwood,P.C.	PCP

Region 6 - Southside Hospital	
DULCE MILAGROS ALMANZAR MD PLLC	PCP
ISLAND HEALTH CARE	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
Brentwood Pediatric & Adolescent Associates, Pc	PCP
Health Medical Pc	PCP
Bay Shore Mental Health Clinic	Behav Health and Substance Abuse
Family Service League	Behav Health and Substance Abuse
Southside Hospital	Hospital
FAMILY MEDICAL CARE OF BAY SHORE PC	PCP
MIREILLE CONSTANT MD	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
Sanctuary East, Ltd	Behav Health and Substance Abuse
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
SBU Children's at Islip (Islip Primary Care)	PCP

Region 7 - Stony Brook University Hospital	
Stony Brook Extended Care	PCP
SBU Children's at East Setauket	PCP
SBU Family Med at East Setauket	PCP
SBU Internists (Primary Care Clinic -PCC)	PCP
SETAUKET PRIMARY MEDICAL CARE PC	PCP
CareFirst Family Medical PC (Fangqin)	PCP
Mather Primary Care (Stony Brook Medical Park)	PCP
Stony Brook Community Medical - Stony Brook (Barbara Boccia)	PCP

Stony Brook Adult Outpatient Psychiatry	Behav Health and Substance Abuse
Stony Brook Medicine	Hospital
Bashir Ahmed MD PLLC	PCP

Region 8 - Southside Hospital/Brookhaven Memorial Hospital Medical Center	
Catholic Charities Talbot House	Behav Health and Substance Abuse
Institute for Rational Counseling, Inc.	Behav Health and Substance Abuse
Long Island Pediatrics Of Brentwood,P.C.	PCP
Myhealth Long Island - Holbrook	PCP
Myhealth Long Island - Oakdale	PCP
Skills Unlimited Oakdale	Behav Health and Substance Abuse
Pollack Center for Recovery and Wellness	Behav Health and Substance Abuse
ADVANTAGECARE PHYSICIANS	PCP
Phoenix Houses of LI, Inc.	Behav Health and Substance Abuse
MID ISLAND INTERNAL MEDICINE, PLLC	PCP
Community Counseling Services	Behav Health and Substance Abuse
Stony Brook Pediatrics of Sayville	PCP
Great South Bay Family Med, W Sayville Office	PCP
YMCA Family Services	Behav Health and Substance Abuse

Region 9 - John T. Mather Memorial Hospital/St. Charles Hospital	
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
Aziz Chaudry	PCP
Port Jefferson Internal Medicine	PCP
LISH at Port Jefferson Station	Behav Health and Substance Abuse
Mather Primary Care (Port Jeff)	PCP
St. Charles Hospital	Behav Health and Substance Abuse
John T. Mather Memorial Hospital	Hospital
St. Charles Hospital and Rehabilitation Center	Hospital
John T. Mather Memorial Hospital Mental Health Clinic	Behav Health and Substance Abuse
John T. Mather Memorial Hospital SUD Clinic	Behav Health and Substance Abuse
Mather Primary Care (Rocky Point)	PCP

Region 10 - John T. Mather Memorial Hospital/St. Charles Hospital/Brookhaven Memorial Hospital Medical Center	
HRH – Elsie Owens Health Center-Coram	PCP
Pediatric Professional Care PC	PCP
Nightingale (Mildred Scharf Ehrenfeld) (site 2 of 2) Farmingville	PCP
Federation of Organizations for NYS Mentally Disabled - Care Coordination Suffolk	Behav Health and Substance Abuse
Peds First	PCP
Concern for Independent Living, Inc.	Behav Health and Substance Abuse
Seafield Services	Behav Health and Substance Abuse

Region 11 - Brookhaven Memorial Hospital Medical Center	
Bellport Primary Care Center (Article 28)	PCP
Brookhaven Memorial Hospital - Outatient Chemical Depenancy Clinic	Behav Health and Substance Abuse
Brookhaven Memorial Hospital Medical Center	Hospital
Brookhaven Memorial Hospital Mental Health Clinic	Behav Health and Substance Abuse
DULCE MILAGROS ALMANZAR MD PLLC	PCP
Family Service League	Behav Health and Substance Abuse
Family Service League	Behav Health and Substance Abuse
Federation of Organizations for NYS Mentally Disabled - Care Coordination at New Brookhaven Townhouse	Behav Health and Substance Abuse
Federation of Organizations for NYS Mentally Disabled - Recovery Concepts Patchogue	Behav Health and Substance Abuse
HRH – Marilyn Shellabarger Health Center-Shirley	PCP
HRH – Patchogue	PCP
LISH at Manorville	Behav Health and Substance Abuse
Medford Mental Health Clinic	Behav Health and Substance Abuse
Myhealth - Sills Road	PCP
Myhealth Brookhaven Family Medicine Suite 203	PCP
Myhealth Long Island - Bellport - Bellport Village	PCP
Myhealth-New Village - Patchogue	PCP
NORTH OCEAN MEDICAL GROUP	PCP
NORTHWELL HEALTH PHYSICIAN PARTNERS	PCP
Outreach Bellport	Behav Health and Substance Abuse
SBU Children's - Expert Pediatric Care	PCP

SBU Children's at Patchogue (Patchogue Primary Care)	PCP
SBU Family Med at Patchogue	PCP
Seafield Services	Behav Health and Substance Abuse
SUFFOLK FIRST MEDICAL, PC	PCP
VXL Medical Care	PCP
Yaphank Center	Behav Health and Substance Abuse

Region 12 - Peconic Bay Medical Center	
Suffolk Primary Health	PCP
Synergy Center for Recovery and Wellness	Behav Health and Substance Abuse
Peconic Pediatrics riverhead	PCP
HRH - Riverhead	PCP
Nightingale (Mildred Scharf Ehrenfeld) (site 1 of 2) Riverhead	PCP
Alternatives Counseling Services	Behav Health and Substance Abuse
Eastern Long Island Hospital - Quannacut Outpatient Services	Behav Health and Substance Abuse
Family Service League	Behav Health and Substance Abuse
LISH at Riverhead	Behav Health and Substance Abuse
Maryhaven Center of Hope, Inc.	Behav Health and Substance Abuse
Seafield Services	Behav Health and Substance Abuse
Suffolk County	Behav Health and Substance Abuse
Westhampton Primary Care	PCP
Seafield Center	Behav Health and Substance Abuse
Catholic Charities	Behav Health and Substance Abuse
Long Island Center For Recovery	Behav Health and Substance Abuse
Meeting House Lane at Hampton Bays FP OFFICE (34 EAST)	PCP
Meeting House Lane at Hampton Bays IM	PCP
SBU Children's at Hampton Bay	PCP
Southampton Pediatrics - Squiretown Rd	PCP

Region 13 - Eastern Long Island Hospital	
East End Physician Services, PC	PCP
Eastern Long Island Hospital	Hospital
Eastern Long Island Hospital - Inpatient	Behav Health and Substance Abuse
ELIH Family Medicine	PCP
HRH – Greenport	PCP
Peconic Pediatrics Southold	PCP

Region 14 - Southampton Hospital	
Meeting House Lane at Amagansett	PCP
East End Pediatrics, PC (Schonfeld)	PCP
East Hampton Family Medicine (Dempsey)	PCP
Phoenix House of LI, Inc.	Behav Health and Substance Abuse
The Dunes	Behav Health and Substance Abuse
Meeting House Lane at Montauk	PCP
Meeting House Lane at Sag Harbor	PCP
Alternatives Counseling Services	Behav Health and Substance Abuse
Hampton Community HealthCare (Harriet Hellman)	PCP
HRH – Kraus Family Health Center of the Hamptons	PCP
Meeting House Lane at Southampton Lower Level Office	PCP
Meeting House Lane at Southampton Upper Level Location	PCP
Shinnecock Indian Health Clinic (Church Street)	PCP
Southampton Hospital	Hospital
Southampton Pediatrics - Meeting House Ln.	PCP
Stony Brook Community Medical - Southampton (Allen Fein)	PCP
Hampton Pediatrics (Persheff)	PCP
Meeting House Lane at Wainscott	PCP
Meeting House Lane at Wainscott Walk-in	PCP
Meeting House Lane at Water Mill	PCP

Huntington Hospital	2
Good Samaritan Hospital	3
St. Catherine of Siena Medical Center	2
Southside Hospital	3
Stony Brook University Hospital	1

St. Charles Hospital	2
John T. Mather Memorial Hospital	2
Brookhaven Memorial Hospital Medical Center	4
Peconic Bay Medical Center	2
Eastern Long Island Hospital	1
Southampton Hospital	1