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IBH Care Delivery Framework Workgroup

June 4, 2026

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Housekeeping

Closed captioning is available via the Zoom toolbar

Slides and additional resources will be shared following the session. This meeting will be recorded for internal purposes only and will not be posted on our website.

Please use Zoom features to “Raise Hand” or use the Chatbox if you have any questions, comments, or concerns

*Please Note: The information shared in today's meeting is accurate as of June 4th, 2026

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Why IBH?

Strategies:

- Leverage existing integrated care capabilities of the NYS Medicaid system
- Provide whole-person care in a coordinated way
- Identify (and respond to) Physical Health needs in Behavioral Health settings

Goals:

- Reduce avoidable IP admissions & ED presentations
- Improve health outcomes
- Reduce premature mortality rates among the target population, those with Moderate-to-Severe-Health conditions

3 Core Elements of the IBH Model

Element 1: Care Integration

- Welcome Visit
- Regular Re-assessment
- Integrated Care Team

Element 2: Care Management

- Care Coordination & Closed-Loop Referral
- Integrated Care Plan

Element 3: Preventive Care & (Physical) Health Promotion

- Track IBH Targeted Health Conditions
- Preventive Care & (Physical) Health Promotion Services

IBH Model Services

Welcome Visit & Regular Re-Assessment

- Informed Consent & Orientation
- Screening & Assessment
- Determine Referrals
- Develop / Review / Update the Integrated Care Plan

Care Coordination & Closed-Loop Referrals

- Scheduling / Following up on Referrals
- Supporting Referral Completion
- Supporting Care Transitions
- Review / Update the Integrated Care Plan

IBH Model Services (continued)

Preventive Care & (Physical) Health Promotion

- Track IBH Targeted Health Conditions
    - Diabetes
    - Hypertension
    - Tobacco Use
    - Hepatitis C
- Screen, Explain Results, Refer / Support / Treat, as Appropriate
- Monitor Progress & Address Barriers

Today's Focus

Integrated Care Team

- Required Care Team Members
- Optional Additions
- Model Objectives
- Workgroup Feedback for Model Design

Integrated Care Planning

- Care Plan Components
- Documentation Requirements
- Workgroup Feedback for Model Design

Future Focus: IBH Model Services

- Care Coordination
- Closed-Loop Referrals
- Preventive Care & Physical Health Promotion

Adapting NYS Model to Clinical Settings

In NYS, IBH Practice Participants represent a range of outpatient settings (e.g., MHOTRS clinics, OASAS clinics, CCBHCs, Hospital-Based clinics, rural settings, urban settings, etc.).
We welcome feedback from as many perspectives as possible to facilitate a design that:

- Leverages existing resources
- Acknowledges existing challenges
- Allows for flexibility
- Encourages forward-thinking solutions

IBH Integrated Care Team

CMS Minimum Care Team Requirements

- Behavioral Health Billing Practitioner
- Physical Health Consultant (on staff or through contract)

Model Objectives Require Additional Team Members

- Care Management
- Preventive Care
- Prescribing Behavioral Health Provider
- Etc.

Example Care Team Members

- Care Coordinator / Nurse Navigator
- Mental Health Professionals (psychologist, LCSW, LMSW, LMHC)
- Social Worker / Case Manager
- Peer Support Specialist
- Credentialed Alcohol & Substance Abuse Counselors (CASAC)
- Nurses (Nurse Practitioner (NP), RN, LPN)
- Physician / Physician Assistant / Primary Care Provider (PCP)
- Specialists (e.g., Cardiologist, Oncologist, Endocrinologist)
- Behavioral Health Prescriber (e.g., psychiatrist, NP in psychiatry)
- Care Manager – (e.g., HH, CCBHC TCM)

Further Discussion

- General feedback?
- Ideas not previously mentioned?
- Send us your questions/comments by email.

Integrated Care Plan Components

- Informed Consent
- Person-Centered Goals
- Screening, Assessment, & Diagnoses
- Referrals, Care Transitions, & Care Team Contact Info
- Care Plan Reviews and Updates

Integrating the Care Plan

The IT Implementation Workgroup Group is designing a model for how this information will be shared across the Care Team, including team members external to the participating agency. The model may potentially leverage:

- HEALTHeLINK
- PSYCKES
- Admission, Discharge, Transfer (ADT) Data
- EHR Continuity of Care Documents (CCDs)

Leading Questions / Food For Thought:

- How might different care team members within your agency document the Care Plan components?
- If Care Plan components were collected through CCDs, what would that look like from your agency's perspective?

Informed Consent

- Consent to Participate
- Consent to Data Sharing
  - HEALTHeLINK
  - PSYCKES
  - OMH / OASAS Required Consents
  - Etc.

Person-Centered Goals

- Behavioral Health goals
- Physical Health goals
- Upstream Drivers of Health (uSDOH) goals
- Access to and engagement with primary care goals
- Progress toward and adjustment of goals

Screening, Assessment, & Diagnoses

Minimum Screening Requirements:

- Access to Primary Care
- Mental Health Conditions
- Substance Use Disorders
- Priority Health Conditions
    - Diabetes
    - Hypertension
    - Tobacco Use
    - Hepatitis C
- Upstream Drivers of Health (uSDOH)
    - Transportation
    - Food Insecurity
    - Housing Assistance

Referrals, Care Transitions & Care Team Contact Info

- Documenting Closed-Loop Referrals
- Noting ED Presentations, Inpatient Admissions, and other care transitions
- Documenting Care Team Communications
- Storing Contact Info for External Care Team Members (those outside the agency)

Care Plan Updates & Reviews

- Updates reflective of referral outcomes, care coordination, transitions in care, follow-up after discharge, updates and progress toward goals, and other clinical changes.
- Reviewed with enrollee at least every 180 days.

Further Discussion

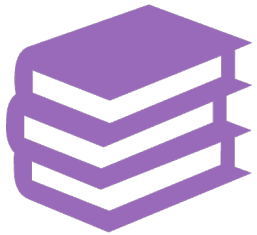
- General feedback?
- Ideas not previously mentioned?
- Send us your questions/comments by email.

Bonus Question

The IBH Model quality strategy will include Patient Reported Outcome Measures (PROMs) that CMS will develop through the PROMIS® Global Health-10 instrument (PROMIS-10).

Zoom POLL: Does your agency currently have PROMIS-10 incorporated in its EHR?

- ❑ Yes
- ❑ No
- ❑ Unsure
- ❑ N/A, I don't represent an IBH participating practice.



Resources

- CMS IBH Model
- DOH Award Announcement
- To contact MCTAC: mctac.info@nyu.edu
- To contact NYS IBH Team: NYS-IBH-Model@omh.ny.gov