

REGION 6 IDN

Detailed Project Plan Guidance

(for review)



All Partner Meeting

1/6/2017

Project Title A1: Behavioral Health Workforce Capacity Development

Project Objective: This project will establish the workforce required to meet the objectives of the DSRIP demonstration. It will increase community-based behavioral health service capacity through the education, recruitment and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of substance use disorder and mental health services. Under this project, each IDN will develop and implement a strategy for addressing its workforce issues using a framework established by a Statewide Behavioral Health Workforce Capacity Taskforce.

This Taskforce will be formed with representation from IDNs and other stakeholders across the state. Through a process facilitated by the State or its delegate, the Taskforce will spearhead the following activities:

- An assessment of the current workforce gaps across the state and IDN regions, informed by an inventory of existing workforce data/initiatives and data gap analysis
- Identification of the workforce capacity needed to meet the demonstration goals and development of a state vision and strategic plan to efficiently implement workforce solutions, for approval by the state

Based on this statewide planning effort, its own community needs assessments, and the community-driven projects it has selected, each IDN will then develop and implement its own workforce capacity plan. The plan must be approved by the state and executed over the course of the demonstration.

Target Population: All Medicaid beneficiaries

Target Participating Organizations: All participating IDN organizations

Related Projects Project A1 is a foundational project that will establish the workforce needed by each IDN to meet the objectives of the DSRIP demonstration. As such, this project is closely tied with every other project being implemented by each IDN, and the plans implemented by IDNs as part of this project should reflect the workforce needs across all projects.

Project Core Components

Phase 1: Form Statewide Behavioral Health Workforce Capacity Taskforce (August-September 2016)

The State will work with IDNs and other stakeholders to form a Statewide Workforce Capacity Taskforce with members drawn from across the mental health and substance use provider and peer support communities in each IDN, as well as other members who can bring relevant experience and knowledge.

Phase 2: Develop inventory of existing workforce data, initiatives and activities; create gap analysis (September – October 2016) Once the Taskforce is formed, it will conduct an assessment of current workforce gaps through the following activities:

1. The development of a statewide inventory of relevant in-process, completed, or proposed future workforce initiatives and data sets.
2. The development of a planning framework that is both qualitative and quantitative. It should include a baseline assessment of the current state of behavioral health workforce: titles, numbers, education and training programs in place, the pipeline of workforce members being produced by existing programs and the in-State retention rates, and current unfilled BH workforce positions
3. Identification of gaps between available data sets, current workforce initiatives/activities and the information needed to enhance SUD and mental health workforce capacity regionally and statewide. This will also include the identification of areas where there are no current adequate data sets.

Phase 3: Develop Statewide Behavioral Health Workforce Capacity Strategic Plan (October 2016 – January 2017)

Based on data and information derived from the inventory of existing workforce initiatives and activities, the Taskforce will engage in a facilitated process to:

- Identify the workforce capacity requirements to meet the demonstration goals
- Develop a statewide strategic plan to enhance workforce capacity across the spectrum of SUD and mental health providers to meet the identified requirements
- The Strategic Plan will include, at a minimum, measurable outcome addressing how the IDNs will develop:
- Strategies for utilizing and connecting existing SUD and BH resources
- Strategies to address gaps in educational preparation of SUD and BH providers to ensure workforce readiness upon graduation;
- Strategies to support training of non-clinical IDN staff in Mental Health First Aid ☐ Strategies for strengthening the workforce in specific areas of expertise such as Master Licensed Alcohol and Drug Counselors (MLADCs), licensed mental health professionals, Peer Recovery Coaches and other front line providers

The Strategic Plan will require approval from the State DHHS.

Phase 4: Develop IDN-level Workforce Capacity Development Implementation Plans (January 2017 – March 2017)

Based on the Statewide Behavioral Health Workforce Capacity Strategic Plan, each IDN will develop its own Workforce Capacity Development Implementation Plan to be executed over the course of the demonstration. The plan will include workforce capacity targets in alignment with guidelines and targets established by the statewide plan, the IDN's community needs assessment, and the community-driven projects selected by the IDN.

IDN plans will be submitted to the State DHHS for approval.

Phase 5: Implement IDN Workforce Capacity Development Plans (March 2017 – December 2018)

Once IDN plans are approved, IDNs will proceed to implementation and report progress against targets on a semi-annual basis. The expectation is that IDNs will use a substantial share of their DSRIP funds, if necessary, to recruit, hire, train and retain the workforce required to meet the DSRIP objectives of more capacity to serve New Hampshire residents with mental health and substance use disorders, including opioid addiction; better integration of physical and behavioral health care; and smoother transitions across care settings.

Process Milestones: In order to be eligible for performance funding associated with this statewide workforce project, IDNs must participate in planning at the statewide level and also design and implement workforce development plans at the IDN level.

Key milestones include:

Phase 1: Participation in formation and kick-off of Statewide Behavioral Health Workforce Capacity Taskforce (Aug-Sept 2016)

Phase 2: Workforce data/initiative inventory assessment (Sept-Oct 2016)

Phase 3: Participation in Development of Statewide Workforce Capacity Strategic Plan (Oct 2016- Jan 2017)

Phase 4: Development, submission, and approval of IDN Workforce Capacity Development Implementation Plan (Jan 2017 – March 2017) 5.

Phase 5: Implementation of IDN Workforce Capacity Development Plan; ongoing semi-annual reporting against targets identified in plan

Additional Information related to inventory of existing workforce data, initiatives, and activities

Project Title A2: Health Information Technology (HIT) Infrastructure to Support Integration

Project Objective: The objective of this project is to develop the HIT infrastructure required to support high-quality, integrated care throughout the state. Each IDN will be required to develop and implement a plan for acquiring the HIT capacity it needs to meet the larger demonstration objectives. To promote efficiency and coordination across the state, this project will be supported by a statewide planning effort that includes representatives from across New Hampshire, a statewide Taskforce. All IDNs will be required to participate in this Taskforce, with members drawn from across the mental health and substance use disorder provider communities in each IDN, as well as other members who can bring relevant experience and knowledge such as the NH Health Information Organization (NHHIO).

Facilitated by DHHS representatives and/or delegates, this Taskforce will be charged with:

- a) Assessing the current HIT infrastructure gaps across the state and IDN regions
- b) Coming to consensus on statewide HIT implementation priorities given demonstration objectives
- c) Identifying the statewide and local IDN HIT infrastructure requirements to meet demonstration goals, including:
 - i. Minimum standards required of every IDN
 - ii. 'Desired' standards that are strongly encouraged but not required to be adopted by every IDN. Interoperability requirements will reference the ONC's 2016 Interoperability Standards Advisory where viable.
 - iii. A menu of optional requirements.

Each IDN will then develop and implement IDN-specific implementation plans and timelines based on the Taskforce's assessment and recommendations, the IDN's current HIT capacity, and the IDN-specific community needs assessment. The four DSRIP demonstration objectives driving the HIT infrastructure work are comprehensive and include:

- 1) Increasing the State's capacity to implement effective community based behavioral health prevention, treatment and recovery models that will reduce unnecessary use of inpatient and ED services, hospital readmissions, and wait times for services.
- 2) Promoting the integration of physical and behavioral health providers in a manner that breaks down silos of care among primary care, SUD and mental health providers.
- 3) Enabling coordinated care transitions for all members of the target population regardless of care setting (e.g. CMHC, community mental health providers, primary care, inpatient hospital, corrections facility, SUD clinic and crisis stabilization unit).
- 4) Supporting IDNs in participating in Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

Using the Taskforce's findings, its community needs assessment, and the community-driven projects it has selected, each IDN will be required to develop a strategy for closing key HIT infrastructure gaps among medical providers, behavioral health providers, and community-based service organizations, and to demonstrate the use of interoperability best practices such as those found in the **Office of the National Coordinator for Health IT's (ONC) 2016 Interoperability Standards Advisory**.

- 5) While not every HIT infrastructure gap can be addressed through this demonstration, examples of current gaps that will be considered include:
- Level of IDN participants utilizing ONC Certified Technologies
 - Level of IDN participants capable of conducting ePrescribing and other core functions such as registries, standardized patient assessments, collection of social determinants, treatment and care transition plans, etc.
 - Level of IDN participants utilizing Certified Electronic Health Record Technology (CEHRT).
 - Level of IDN participants capable of conducting ePrescribing and other core CEHRT functions such as registries, standardized patient assessments, collection of social data, treatment and care transition plans, etc.
 - Ability for IDN participants to exchange relevant clinical data with each other and with statewide facilities such as New Hampshire Hospital via health information exchange (HIE) standards and protocols.
 - Ability for IDN participants to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2).
 - Ability for IDN participants to use comprehensive, standardized physical and behavioral health assessments.

- Level of IDN participants in their ability to share a community-wide care plan to support care management, care coordination, patient registries, population health management, and quality measurement.
- Ability for IDN participants and the State’s Medicaid HIT infrastructure, comprised of State and managed care organization (MCO) vendor systems, to create interoperable systems for the exchange of financial, utilization, and clinical quality data for operational and programmatic evaluation purposes.
- Ability for IDN participants to directly engage with their patients for items including but not limited to bi-directional secure messaging, appointment scheduling, viewing care records, prescription management, and referral management.

Target Population: All Medicaid beneficiaries

Target Participating Organizations All participating IDN organizations Related Projects Project A2 is a foundational project to support statewide and IDN-level planning efforts associated with addressing select HIT gaps. As such, this project is closely tied with any project being implemented with HIT needs.

Project Core Components

Phase 1. Statewide HIT Taskforce: Facilitated Current State Assessment (July 2016 – September 2016)

A facilitated current-state assessment of HIT for participating members of the IDNs will allow for the creation of a gap analysis at both the IDN and State levels. This data collection will feed into a facilitated statewide discussion regarding required, desired, and optional HIT infrastructure.

Key work steps in this phase include:

- a. Develop standardized current-state assessment tool. This tool will reference the ONC’s 2016 Interoperability Standards Advisory.
- b. Conduct an IDN-member assessment of existing and scheduled HIT efforts and develop a statewide report.
- c. Taskforce (or delegate) will conduct an updated review of pertinent State/Federal laws re: patient consent & exchange of behavioral health and SUD information to ensure an understanding of any related legal constraints.
- d. Create a gap analysis between each IDN-member assessment in relation to the ability to support DSRIP demonstration objectives.

Phase 2. Statewide HIT Taskforce: Works Toward Consensus on a Set of Minimally Required, Desired, and Optional HIT HIE Infrastructure Projects for IDNs to Pursue (October 2016 – March 2017)

In order to achieve alignment across IDNs, each IDN will participate in a facilitated, statewide consensus development process to determine the: 1) minimally required, 2) desired, and 3) optional HIT infrastructure projects that IDNs should pursue. Once this alignment is attained, each IDN will develop and implement its own IDN-specific HIT implementation plan. HIT governance practices will also be examined in the context of seeking HIT governance compatibility across IDNs.

Alignment goals will center on the following issues which are designed to help close the gaps in HIT that will support the DSRIP demonstration:

- a. Support for achievement of overall DSRIP demonstration goals, within the context of current HIT infrastructure gaps and HIT assessment. Potential statewide and regional priorities could include determination and definition of:
 - i. Acceptable levels of ONC Certified Technologies adoption and electronic health record functionality.
 - ii. The desired transaction sets, methods, and mechanisms for health information exchange (HIE) between IDN participants. The expectation is interoperability requirements will reference the ONC’s 2016 Interoperability Standards Advisory where viable.
 - iii. Requirements scope for a shared community care record across the care continuum (e.g. physical health providers, behavioral health providers, community supports).
- b. Enabling clinical outcomes and financial performance measurement and reporting functions within the IDN, across IDNs, and between IDNs and the State. This would include items such as:
 - i. Electronic Clinical Quality Measures (eCQMs)8.
 - ii. Utilization reporting (e.g., IDN, type of service, geographic, temporal, co-morbidity, community supports).

- iii. Financial performance reporting.
- iv. Managing reporting between IDNs and the State using a State-approved standardized format for the electronic interface.
- v. State support of IDNs' analytic capacity with State-approved standardized data sets to be provided by the State and the State's MCO partners.

Phase 3. Individual IDN Task: Develop Future State IDN-Specific Implementation Plans & Timelines (April 2017 – June 2017)

Each IDN will develop a HIT implementation plan and timeline that will be approved by the State in order for the IDN to be eligible for incentive payments associated with this project. The State will be providing additional information about the format and requirements related to this plan. The plan will allow for regional differences in HIT capacity, prior investment, and future plans. The implementation plan will build upon the Assessment and Consensus phases and work to reduce the HIT gaps identified in the Project Objective section of this document. There is expected to be a "floor requirement" and a "stretch goal" for each IDN plan so that each IDN shows progress over the five-year period, based on identified process milestones. These plans will be reviewed and approved prior to the State authorizing use of DSRIP funds for implementation.

- a. At a minimum, the HIE integration plan component of the IDN's HIT implementation plan will include the following IDN provider(s): hospital, CMHC, community mental health providers, primary care, SUD, and DRF participants. The HIE integration plan will also include New Hampshire Hospital and state the level of anticipated HIE integration with other IDN participants such as County nursing home, County correction facility, developmental disability agency, etc.
- b. The IDN's HIT implementation plan will show, at a minimum, how and when all of an IDN's HIE participants will be utilizing ONC Certified Technologies and functions, and adhering to the ONC's 2016 Interoperability Standards Advisory.
- c. The IDN's HIT implementation plan will describe how certain key population health management capabilities will be supported, such as individual and community risk assessments, care coordination and care management, health care transitions support, and quality measurement.
- d. The IDN's HIT implementation plan will describe the clinical and financial analytic systems required inputs and outputs, using the State-approved, interoperable standard.
- e. The IDN's HIT implementation plan may include concepts and components that go beyond the HIT gaps identified in the Project Objective section of this document if they can demonstrate overall value to the DSRIP Demonstration implementation.

Phase 4. Individual IDN Task: Implementation of IDN-specific Plan (September 2017 – December 2018)

Once its plan is approved and the State authorizes use of DSRIP funds for HIT, each IDN will be expected to implement its HIT plan over the course of a 16-month period. The plan will include specific objectives, timelines, and milestones allowing the IDN to track its progress and the State and CMS to oversee implementation.

Process Milestones

- 1) IDN Participation in Statewide HIT Taskforce: Current State Assessment (July 2016 – September 2016)
 - a. Taskforce Convened
 - b. Assessment Conducted
 - c. Assessment Report Published
- 2) IDN Participation in Statewide HIT Taskforce: Achieve Consensus on a Set of Minimally Required, Desired, and Optional HIT HIE Infrastructure Projects for IDNs to Pursue (October 2016 – March 2017)
 - a. Consensus Meetings Held
 - b. Consensus Report Published
- 3) Individual IDN Milestone: Develop Future State IDN-Specific Implementation Plans and Timelines (April – August 2017)
 - a. IDN Plans Developed
 - b. IDN Submits Draft Plan
 - c. State Reviews Draft
 - d. State Communicates Comments on Draft
 - e. IDN Submits Final Plan
 - f. State Approves/Denies Plan
- 4) Individual IDN Milestone: Implementation of IDN-specific Plan (September 2017 – December 2018)

Project Title B1: Integrated Healthcare

Project Objective: The integration of care across primary care, behavioral health (mental health, substance misuse/SUD) and social support service providers is a foundational core competency requirement for participants in the demonstration. This project will support and incentivize primary care and behavioral health providers to progress along a path from their current state of practice toward the highest feasible level of integrated care based on the approach described in **SAMHSA's Standard Framework for Levels of Integrated Healthcare**. The goal of integrating these services is to build a delivery system that effectively and efficiently prevents, treats and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of service. Implementing this strategy will materially impact the IDN's ability to achieve key demonstration goals: reduce avoidable acute care admissions and ED utilization, and measurably improve the health status for Medicaid beneficiaries and other state residents.

Target Population: Beneficiaries with behavioral health conditions or at risk for such conditions will be the primary sub-population expected to benefit from the project.

Target Participating Organizations: Organizations or individual IDN network providers who provide primary care, mental health services, substance misuse/SUD services, social support services providers. This project represents the foundational core competencies for primary care and behavioral health providers across each IDN network. As such, the project requirements must be implemented in coordination with all other demonstration projects, including Project A1 (Behavioral Health Workforce Capacity Development) and A2 (HIT Infrastructure to Support Integration). This project must also be closely coordinated with the implementation of the three Community-driven Projects Project Core Components As explained in more detail below, under this project each IDN will provide training and support to its primary care practices, community mental health centers, and other network medical and behavioral health providers in becoming a "coordinated care practice" or an "integrated care practice," depending on what is practical given the practice's current level of integration, patient panel size and risk profile, and available resources.

Definitions "Integrated Healthcare" is defined for this project as employing strategies and tactics within primary care and behavioral health practices that will measurably enhance collaboration, (defined as how communication flows among primary care and BH providers and support staff) and integration (defined as how services are delivered and practices are organized and managed).

Two Tiers of Integration: Coordinated Care Practice and Integrated Care Practice. The project has been designed to balance a) the need to promote integrated health across as many organizations in an IDN as possible with b) the reality that providers vary in scale and current baseline levels of integration. Some providers—in particular some FQHCs and CMHCs—are already providing highly integrated primary, mental health, and SUD care, while other practices have not yet begun this work or lack the size and scale to support the technology and staffing required to integrate care.

IDNs will work with network primary care and BH providers to assist them in securing designation as a Coordinated Care Practice or an Integrated Practice. In advancing along the integration continuum, all primary care and behavioral health practices within an IDN are expected to meet 'Coordinated Care Practice' designation. All such providers will be expected to progress as far as feasibly possible toward Integrated Practice designation during the demonstration period. As part of its Project Plan, IDNs also will develop the criteria used to identify practices within the IDN that will meet the additional requirements necessary for Integrated Care Practice designation. As part of the planning process in the first half of 2017, IDNs will work with their primary care and BH providers to:

- (a) assess their current state of practice against the designation requirements to identify gaps and
- (b) to define steps and resources needed to achieve the designation(s) judged to be feasible by the provider and the IDN during the period of the demonstration.

Key elements of the project include the following:

Coordinated Care Practice designation requirements: Comprehensive Core Standardized Assessment and Shared Care Plan Use of Comprehensive Core Standardized Assessment process and care plan that will be shared among core team members. The assessment process (conducted at a minimum annually) will be the basis for an individualized care plan used by the care team to guide the treatment and management of the target sub- population.

The assessment will include the following domains: **demographic, medical, substance use, housing, family & support services, education, employment and entitlement, legal, risk assessment including suicide risk, functional status (activities of daily living, instrumental activities of daily living, cognitive functioning).**

In addition, pediatric providers will ensure that all children receive standardized, validated developmental screening, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; and use Bright Futures or other American Academy of Pediatrics recognized developmental and behavioral screening system.

Assessment includes universal screening via full adoption and integration of, at minimum, two specific evidenced based screening practices (e.g): 1. Depression screening (e.g., PHQ 2 & 9) and 2. Brief intervention and referral to treatment in primary care (SBIRT).

Multi-disciplinary core team

Multi-disciplinary core team is available to support individuals at risk for or with diagnosed behavioral health conditions or chronic conditions that includes PCPs, behavioral health providers (including a psychiatrist), assigned care managers or community health worker. Core team members are not required to be physically colocated or to be part of the same organization, although co-location is strongly encouraged where feasible given the size and volume of a particular practice.

Teams may also include peer specialists, pharmacists, social support service providers, and pediatric providers as appropriate to individual needs. As part of a basic educational program, core team members will have adequate training in management of chronic diseases including diabetes hyperglycemia, dyslipidemia, hypertension, and the nature of mental health disorders and substance use disorders to enable team members to recognize the disorders and as appropriate, to treat, manage or refer for specialty treatment as appropriate, and to know how to work in a care team. Practice staff who are not involved in direct care should also receive training in knowledge and beliefs about mental disorders that can aid in their recognition, and management in special situations.

Care manager/Community Health Worker role is well-defined and includes providing support to the patient in meeting care plan goals (including in home or community-based settings), providing support to core team members to ensure that the teams is coordinating care and that communication among team members is working to optimize patient care and improve health status of the care team's patient population

Care coordination is supported by documented work flows, joint service protocols and communication channels with community based social support service providers Coordination with other care coordination/management programs or resources that may be following the same patient is critical. To the extent possible, only one care coordinator/manager is playing a lead role in managing the patient's care plan. Includes adherence to New Hampshire Board of Medicine guidelines on opioid prescribing.

Information Sharing: Care Plans, Treatment Plans, Case Conferences

Information is regularly shared among team members using:

- o Documented work flow that ensures timely communication of a defined set of clinical and other information critical to diagnosis, treatment and management of care. It is expected that communication be enabled via electronic means (e.g., shared EHR or coordinated care management system) or that providers are advancing along a continuum towards electronic communication.

- o On behalf of patients with significant behavioral health conditions or chronic conditions, regularly scheduled (minimum monthly) core team (plus other providers as needed) case conferences.

- o Documented workflows that incorporate a communication plan inclusive of protocols related to what information is provided to treatment providers, what is available to community based organizations and how privacy will be protected. Closed-loop referral capabilities (electronic or non-electronic).

Standardized workflows and protocols

- Written roles, responsibilities, and workflows for core team members
- Protocols to ensure safe care transitions from institutional settings back to primary care, behavioral health and social support service providers.
- Intake procedures that include systematically solicit patient consent to confidentially share information among providers

Additional Integrated Practice designation requirements:

- All of the requirements for the Coordinated Care Practice designation above

- PLUS Adoption of both of the following evidence-based interventions:

1. Medication-assisted treatment (MAT)

2. Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either

through use of the IMPACT or other evidence-supported model.

- Use of technology to identify at-risk patients, plan their care, monitor/manage patient progress toward goals, ensure closed loop referral. Such tools will include a shared or interoperable EHR and/or electronic care coordination/management system that incorporate the Comprehensive Core Standardized Assessment and Care Plan
- Documented work flows, joint service protocols and communication channels with community based social support service providers, including closed-loop referral capabilities. (See also the Statewide Health Information Technology project A2)

Process Milestones

As part of the 2017-2018 semi-annual IDN reporting process, IDNS are required to demonstrate that organizations participating in this project have achieved the following process milestones during, or in advance of, the timeframe noted. All primary care and behavioral health practices within an IDN are expected to meet 'Coordinated Care Practice' designation. As part of its Project Plan, IDNs will identify practices within the IDN that will meet the additional requirements necessary for Integrated Care Practice designation.

Jan-Jun 2017 Reporting Period

Development of implementation plan, which includes:

- a. Implementation timeline
 - i. IDNs may establish the timeline for completion of both Coordinated Care and Integrated Care designations. However, the Coordinated Care Practice designation should be achieved by all primary care and behavioral health practices within an IDN no later than December 31, 2017. For those practices/providers that will seek Integrated Care Practice designation, additional requirements must be met by no later than December 31, 2018.
- b. Project budget
- c. Work force plan: staffing plan; recruitment and retention strategies as applicable
- d. Key organizational/ provider participants
- e. Organizational leadership sign-off, demonstrating that the leadership team responsible for implementing integrated care standards has been identified for every relevant practice and is strongly supportive of care integration.

During this period, all IDN participating providers must demonstrate progress along SAMHSA Framework for Integrated Levels of Care by identifying or developing the following:

- a. Comprehensive Core Standardized Assessment and screening tools applicable to adults, adolescents and children
- b. Shared Care Plan for treatment and follow-up of both behavioral and physical health to appropriate medical, behavioral health, community, and social services.
- c. Protocols for patient assessment, treatment, management
- d. Referral protocols including to those to/from PCPs, BH providers, social service providers, Hospitals, and EDs
- e. Core team meeting/communication plan and relevant workflows for communication among core care team and other patient providers, including case conferences
- f. Written roles and responsibilities for core team members and other members as needed,
- g. Training plan for each member of the core team and extended team as needed
- h. Training curricula for each member of the core team and extended team as needed
- i. Agreements with collaborating providers and organizations including:
- j. Referral protocols ii. Formal arrangements (Contract or MOU) with community based social support service providers iii. Coverage schedules iv. Consultant report turnaround time as appropriate
- k. Evaluation plan, including metrics that will be used as ongoing impact indicators to provide the IDN with sense of whether they are on the path to improve broader outcome measures that drive payment
- l. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to integration framework (e.g., using the Maine Site Self-Assessment Evaluation Tool for the Main Health Access Foundation Integration Initiative)

Jul-Dec 2017 Reporting Period

By December 31, 2017, all primary care and behavioral health practices must have achieved the Coordinated Care Practice designation requirements described in the Core Project Components above.

During this reporting period, providers must demonstrate progress along SAMHSA Framework for Integrated Levels of Care by meeting the following additional milestones.

- a. Implementation of workforce plan (staffing plan; recruitment and retention strategies)
- b. Deployment of training plan
- c. Use of annual Comprehensive Core Standardized Assessment
- d. Use of Shared Care Plan
- e. Operationalization of Core Team meeting/communication plan, including case conferences
- f. Use of shared EHR, electronic coordinated care management system, or other documented work flow that ensures timely communication of a defined set of clinical and other information critical to diagnosis, treatment and management of care

Initiation of data reporting

- a. Number of Medicaid beneficiaries receiving Comprehensive Core Standardized Assessment (during reporting period and cumulative), vs. projected.
- b. Number of Medicaid beneficiaries scoring positive on screening tools
- c. Number of Medicaid beneficiaries scoring positive on screening tools and referred for additional intervention
- d. Number of new staff positions recruited and trained (during reporting period and cumulative), vs. projected
- e. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Jan-Jun 2018 Reporting Period

Ongoing data reporting

- a. Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized Assessment (during reporting period and cumulative), vs. projected
- b. Number of Medicaid beneficiaries scoring positive on screening tools
- c. Number of Medicaid beneficiaries scoring positive on screening tools and referred for additional intervention
- d. Number of new staff positions recruited and trained (during reporting period and cumulative), vs. projected
- e. New staff position vacancy and turnover rate for period and cumulative vs projected
- f. Impact indicator measures as defined in evaluation plan

Jul-Dec 2018 Reporting Period

By December 31, 2018, all practices identified for Integrated Care Practice designations must have achieved the additional requirements described in the Core Project Components above.

Ongoing data reporting

- a. Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized Assessment (during reporting period and cumulative), vs. projected
- b. Number of Medicaid beneficiaries scoring positive on screening tools
- c. Number of Medicaid beneficiaries scoring positive on screening tools and referred for additional intervention
- d. Number of new positions recruited and trained (during reporting period and cumulative), vs. projected
- e. New staff position vacancy and turnover rate for period and cumulative vs projected
- f. Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence supported program elements

C1 Project Title C1: Care Transition Teams

Project Objective: Time-limited care transition program led by a multi-disciplinary team that follows the 'Critical Time Intervention' (CTI) approach to providing care at staged levels of intensity to support patients with serious mental illness during transitions from the hospital setting to the community.

CTI has been applied with veterans, people with mental illness, people who have been homeless or in prison, and many other populations. It is aimed at preventing readmissions to acute care, inappropriate use of the ED, and recurring homelessness among individuals with mental health conditions.

Target population: Adults with serious mental illness transitioning from the hospital setting into the community.

Target Participating Organizations: Hospitals (including New Hampshire Hospital), primary care providers, behavioral health providers, community-based social services organizations
Related Projects N/A
Project Core Components
The project requires implementation of a three-phase model, based on the evidence-based Critical Time Intervention program. Each of the phases is approximately three months. The intervention is led by a single bachelor or master's degree caseworker trained in CTI and supervised by a mental health professional.

Key elements of the project include the following:

Phase 1: The case worker provides support and begins to connect client to providers and agencies that will gradually assume the primary support role.

During Phase 1, the case worker:

- Meets client prior to discharge
- Collaborates with the mental health professional and primary care provider (including VA providers for veterans dually enrolled in VA care and Medicaid care) on client assessment(s) and, with client, develop and document a care transition plan
- Makes home visits to meet with client and caregivers, teach conflict resolution skills, and provide support as needed

During Phase 2: the caseworker:

- Identifies and meets with existing supports and introduces the client to new supports as needed.
- monitors and strengthens support network and client's self-management skills
- assesses support network effectiveness and helps client to makes changes as needed
- monitors client progress and encourages client to increase levels of responsibility.

During Phase 3: The caseworker:

- completes the termination of CTI services with the client's support network safely in place.

Process Milestones

As part of the 2017-2018 semi-annual IDN reporting process, IDNs are required to demonstrate that organizations participating in this project (as identified in the approved IDN Project Plan) have achieved the following process milestones during, or in advance of, the timeframes noted.

Jan-Jun 2017 Reporting Period

1. Development of implementation plan, which includes:

- a. Implementation timeline
- b. Project budget
- c. Work force plan: CTI staffing plan; recruitment and retention strategies
- d. Projected annual client engagement volumes
- e. Key organizational/ provider participants

2. Design and development of clinical services infrastructure, which includes identification or development of:
 - a. Standardized protocols for Care Transition Team model including patient identification criteria, standardized care transition plan, case worker guidelines, and standard processes for each of the program's three phases
 - b. Roles and responsibilities for CTI team members
 - c. Training plan
 - d. Training curricula
 - e. Agreements with collaborating organizations, including New Hampshire Hospital if applicable
 - f. Evaluation plan, including metrics that will be used to measure program impact
 - g. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements (e.g., re-hospitalization data)

July-Dec 2017 Reporting Period

3. Operationalization of program
 - a. Implementation of workforce plan
 - b. Deployment of training plan
 - c. Implementation of any required updates to clinical protocols, or other operating policies and procedures
 - d. Use of assessment, treatment, management and referral protocols
4. Initiation of data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Jan-Jun 2018 Reporting Period

5. Ongoing data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Staff vacancy and turnover rate for period and cumulative vs projected
 - d. Impact measures as defined in evaluation plan

Jul-Dec 2018 Reporting Period

6. Ongoing data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Staff vacancy and turnover rate for period and cumulative vs projected

D3: Expansion in intensive SUD Treatment Options, including partial-hospital and residential care

Project Objective: This project is aimed at expanding capacity within an IDN for delivery of partial intensive outpatient, partial hospital, or residential treatment options for SUD, in conjunction with expansion of lower acuity outpatient counseling. These services are intended to result in increased stable remission of substance misuse, reduction in hospitalization, reduction in arrests, and decrease in psychiatric symptoms for individuals with co-occurring mental health conditions.

Target Population: Individuals with substance use disorders (with or without co-occurring mental health disorders)
Within the target population, priority populations include:

- Pregnant women
- Individuals that have experienced an overdose in past 30 days
- IV drug users
- Custodial parents of minor children

Target Participating Organizations: Behavioral health organizations seeking to expand service options

Related Projects: IDNs implementing this project should coordinate with and build on the Core Competencies being required as part of Project B1 (integration of behavioral health and primary care), including the use of screening, brief intervention, and referral to treatment (SBIRT). Workforce requirements for this project should be incorporated into the IDN's Workforce Capacity Development Implementation Plan in conjunction with Project A1 (Behavioral Health Workforce Capacity Development).

Key elements of the project include the following:

1. At least 1 higher intensity service:
 - Intensive Outpatient (IOP)
 - Partial Hospitalization (PH)
 - Non-hospital based residential treatment services, Ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services, should be offered concurrent or in tandem, as indicated, with treatment services for mental health (MH), substance use (SUD) and co-occurring (COD) disorders.

Medication assisted treatment services (MAT) are also a critical component for effectively addressing substance used disorders (see project D1, specifically focused on medication assisted treatment). Providers will provide concurrent treatment of co-occurring tobacco use disorder.

2. Regular outpatient counseling for substance use disorders (and/or co-occurring disorders), provided by qualified practitioners, for individuals with lower levels of acuity broadly across the spectrum of health and social service programs within the IDN.

Process Milestones

Jan-Jun 2017 Reporting Period

1. Development of implementation plan, which includes:
 - a. Implementation timeline
 - b. Project budget
 - c. Work force plan: staffing plan; recruitment and retention strategies
 - d. Projected annual client engagement volumes
 - e. Key organizational/ provider participants

2. Design and development of clinical services infrastructure, which includes identification or development of:
 - a. Standardized assessment tool(s)
 - b. Patient assessment, treatment, management, and referral protocols
 - c. Roles and responsibilities for team members
 - d. Training plan
 - e. Training curricula
 - f. Agreements with collaborating organizations
 - g. Evaluation plan, including metrics that will be used to measure program impact
 - h. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

July-Dec 2017 Reporting Period

3. Operationalization of program
 - a. Implementation of workforce plan
 - b. Deployment of training plan
 - c. Implementation of any required updates to clinical protocols, or other operating policies and procedures
 - d. Use of assessment, treatment, management and referral protocols
4. Initiation of data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Jan-Jun 2018 Reporting Period

5. Ongoing data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Staff vacancy and turnover rate for period and cumulative vs projected
 - d. Impact measures as defined in evaluation plan

Jul-Dec 2018 Reporting Period

6. Ongoing data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Staff vacancy and turnover rate for period and cumulative vs projected
 - d. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Additional Information

Additional information on the treatment of substance use and co-occurring disorders can be found at: [The Substance Abuse Mental Health Services Administration \(SAMHSA\) Treatment Improvement Protocols \(TIPs\)](http://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS) are available at: <http://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS> [The SAMHSA Technical Assistance Publications \(TAPs\)](http://store.samhsa.gov/list/series?name=TechnicalAssistance-) are available at: <http://store.samhsa.gov/list/series?name=TechnicalAssistance->

Project Title E5: Enhanced Care Coordination for High-Need Populations

Project Objective: This project aims to develop comprehensive care coordination/management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions. These services are intended to maintain or improve an individual's functional status, increase that individual's capacity to self-manage their condition, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.

Target Population:

- Adults (18 years or older): individuals with behavioral health disorders (specifically, serious mental illness or Substance Use Disorders, including opioid addiction) with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors (such as homelessness) that are barriers to community living and well-being
- Children (< 18 years): children diagnosed with chronic serious emotional disturbance
- Developmentally Disabled (DD) population Aged Blind and Disabled (ABD) population with co-occurring behavioral health disorders

Target Participating Organizations:

- Primary care providers
- Behavioral health providers (mental health and SUD)
- Community-based social support service organizations Related Projects
- IDNs implementing this project should coordinate with and build on the Core Competencies being developed as part of Project B1 (integration of behavioral health and primary care)
- Health information technology (HIT) requirements for this project should be incorporated into the IDN's HIT planning process in conjunction with Project A2 (HIT Infrastructure to Support Integration)
- Workforce requirements for this project should be incorporated into the IDN's Workforce Capacity Development Implementation Plan in conjunction with Project A1 (Behavioral Health Workforce Capacity Development) Project Core Components
- IDNs implementing this project will define its specific care coordination models and exact target populations; however, core required elements of any model include:
 - o Identified care teams that include care coordinator/managers, PCPs, behavioral health providers
 - o Systematic strategies to identify and intervene with target population
 - o A comprehensive core assessment and a care plan for each enrolled patient, updated on a regular basis
 - o Care coordination services that facilitate linkages and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources
 - o Transitional care coordination across settings, including from the hospital to the community
 - o Technology-based systems to track and share care plans and to measure and document selected impact measures
 - o Robust patient engagement process around information sharing consent
 - o Coordination with other care coordination/management programs or resources that may be following the same patient so that to the extent possible, only one care coordinator/manager is playing a lead role in managing the patient's care plan

As part of the 2017-2018 semi-annual IDN reporting process, IDNs are required to demonstrate that organizations participating in this project (as identified in the approved IDN Project Plan) have achieved the following process milestones during, or in advance of, the timeframes noted.

Jan-Jun 2017 Reporting Period

1. Development of implementation plan, which includes:
 - a. Implementation timeline

- b. Project budget
 - c. Work force plan: staffing plan; recruitment and retention strategies
 - d. Projected annual client engagement volumes
 - e. Key organizational/ provider participants
2. Design and development of clinical services infrastructure, which includes identification or development of:
- a. Description of target population and eligibility criteria, including rationale for intervention with this target population that aligns with the goals of the Transformation Demonstration
 - b. Standardized assessment tool(s)
 - c. Patient assessment, treatment, management, and referral protocols, including:
 - i. Method for rapidly identifying and engaging the target population in community delivered care or self-management strategies
 - ii. Model for ongoing care coordination/management and intervention with the target population, indicating strategies and mechanism through which the model will improve management of the chronic conditions
 - d. Roles and responsibilities for care team members
 - e. Training plan
 - f. Training curricula, including standard set of care coordinator/manager knowledge and skills requirements and qualified training resources for care managers/coordinators
 - g. Agreements with collaborating organizations, including community-based social support organizations
 - h. Evaluation plan, including metrics that will be used to measure program impact (e.g., number of successful linkages to social support services, change in utilization of ED and inpatient services for those enrolled/active for more than 3 months)
 - i. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

July-Dec 2017 Reporting Period

- 3. Operationalization of program
 - a. Implementation of workforce plan
 - b. Deployment of training plan
 - c. Implementation of any required updates to clinical protocols, or other operating policies and procedures
 - d. Use of assessment, treatment, management and referral protocols
- 4. Initiation of data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Jan-Jun 2018 Reporting Period

- 5. Ongoing data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Staff vacancy and turnover rate for period and cumulative vs projected
 - d. Impact measures as defined in evaluation plan

Jul-Dec 2018 Reporting Period

- 6. Ongoing data reporting
 - a. Number of individuals served (during reporting period and cumulative), vs. projected
 - b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - c. Staff vacancy and turnover rate for period and cumulative vs projected
 - d. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements