



**New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver
DRAFT PROJECT AND METRICS SPECIFICATION GUIDE**

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Introduction to Project and Metrics Specification Guide

Overview of Transformation Waiver Demonstration

On January 5, 2016, New Hampshire secured a five-year, \$150 million Medicaid 1115 waiver to transform the state's delivery system for Medicaid beneficiaries with mental health and substance use disorders. Known as the "Building Capacity for Transformation Waiver," this transformation initiative represents an unprecedented opportunity to strengthen community-based mental health services, combat the opiate crisis, and drive delivery system reform. The waiver's five-year demonstration will foster new collaboration among providers and improve the quality and access to the behavioral health delivery system more broadly for all New Hampshire residents, inclusive of children, youth, and adults, in need of mental health or substance use disorder services.

Under the transformation initiative, change will be driven by regionally-based networks of medical, mental health, substance use disorder and social service providers. Over the five-year initiative, New Hampshire has the authority to invest up to \$30 million per year to support these "Integrated Delivery Networks," or IDNs, in undertaking *projects* aimed at furthering the objectives of the waiver and meeting performance *metrics* in IDN Service Regions across New Hampshire.

This document ("The Project and Metrics Specification Guide") provides additional detail and specifications on those projects and metrics, building on four other key documents outlining how New Hampshire intends to implement the transformation initiative:

1. The Special Terms and Conditions (STCs) of the waiver, which set forth in detail the agreement between New Hampshire and the federal government on how the transformation initiative will be financed and implemented, including the allowable uses of funds, expectations for the state and for IDNs, and reporting and oversight obligations. The STCs were approved on January 5, 2016.
2. A draft "Planning Protocol" (which will become Attachment C of the STCs), submitted to CMS on March 1, 2016
3. A draft "Funding and Mechanics Protocol" (which will become Attachment D of the STCs), submitted to CMS on March 1, 2016
4. A draft IDN Application, released for public comment on March 31, 2016

Since these documents may be modified based on CMS or public input, this project specification guide also is subject to change until final approval of the two protocols by CMS. (Please visit <http://www.dhhs.nh.gov/section-1115-waiver/index.htm> for additional detail and background documents on the waiver).

The goals of the transformation initiative are to build greater behavioral health capacity, improve integration of physical and behavioral health, and improve care transitions for Medicaid beneficiaries, inclusive of children, youth, and adults. The initiative also seeks to promote the transition to Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment.

The initiative furthers these goals by allowing IDNs to earn performance-based incentive payments for meeting process milestones and clinical outcome targets designed to measure progress in each of these areas. The initiative is not a grant program, and so it is only through achieving specific process milestones and outcome metrics that the IDNs can receive fiscal incentive payments. Moreover, the State must meet statewide outcome targets or lose access to some of the \$150 million in federal funding.

IDNs will pursue performance goals by implementing a set of six projects, described further below and detailed in the Project Specifications section of this document. Three of the projects are mandatory for all IDNs, and three will be selected by each IDN from a menu.

Once IDNs have been selected through the IDN Application process during the summer of 2016, organizations participating in the IDN will receive initial Project Design and Capacity Building Funds, identify the projects that the IDN will implement, and prepare an “IDN Project Plan.” The Project Plan will provide a blueprint of the work that an IDN intends to undertake, explain how its work responds to community-specific behavioral health needs and furthers the objectives of the transformation initiative, and provide details on the IDN’s composition and governance structure. IDNs are required to engage community stakeholders as part of the development of the IDN Project Plan. The State and an Independent Assessor under contract to the State will evaluate and approve IDN Project Plans as early as November 2016. IDNs with approved IDN Project Plans are then eligible to proceed with project implementation and receive performance-based incentive payments.

From 2017-2020, IDNs will be able to receive semi-annual performance-based incentive funding up to a pre-determined maximum annual amount by achieving or exceeding defined targets for process milestones and outcome metrics. Each project will have associated process and outcome metrics that must be achieved for IDNs to earn funding associated with a project in a given year. The way IDNs earn incentive payments will shift over the duration of the waiver, from a focus on rewarding achievement of process milestones during 2017-2018, to rewarding improvement on outcome-based metrics in 2019-2020.

Project Menu Overview

Mandatory Foundational Projects

IDNs will pursue performance goals by implementing a set of six projects. Three of these projects are foundational to the transformation initiative, and, therefore, are mandatory for all IDNs. These projects are the cornerstone of the transformation initiative and will require a significant majority of the IDN’s available planning, resources, and organizational bandwidth to implement. In turn, these projects are intended to support interventions that will drive much of improvement in performance outcomes the IDNs are accountable for achieving.

Mandatory Foundational Projects: Statewide Projects

Two of the mandatory foundational projects begin with a statewide planning process involving all IDNs and are subsequently implemented locally by each IDN:

- Behavioral Health Workforce Capacity Development
- Health Information Technology (HIT) Infrastructure to Support Integration

The decision to begin both of these projects with a statewide planning process reflects the fact that workforce development and HIT challenges are issues that affect all regions in New Hampshire and that would benefit from a coordinated, statewide response. Statewide planning efforts for each of these projects will begin with identification of the workforce capacity and technology required to meet transformation initiative goals and with assessments of the current workforce and HIT gaps across the state and IDN regions. These analyses will be followed by the development of a future state vision that incorporates strategies to efficiently implement statewide or regional technology and workforce solutions. Using the findings and recommendations from the statewide planning efforts, IDNs will be required to develop their own approach to closing the work force and technology gaps in their regions. IDNs must participate in these projects and fulfill state-specified requirements in order to be eligible for performance funding.

Mandatory Foundational Projects: Core Competency Project

In addition to the two statewide projects, every IDN will implement the Integrated Healthcare project. It focuses on building the core competencies required to ensure the integration of care across primary care, behavioral health (mental health and substance misuse/SUD) and social support service providers. As part of better integrated care, the core competency project will also incentivize practices to adopt a limited number of critical transformation initiatives, such as Screening, Brief Intervention and Referral to Treatment (SBIRT); medication-assisted treatment for substance use disorders, and family-focused, preventative care for children and youth at risk of or facing behavioral health challenges. The State recognizes that practices vary widely in size, scale, and current baseline levels of integration, as well as in their current use of critical transformation initiatives. With respect to some core competencies, such as integration of care, the project is designed to facilitate a practice's movement along a path from its current state of practice toward the highest feasible level of performance rather than requiring a one-size-fits-all outcome within the timeframe of the five-year transformation initiative.

Projects Selected by IDNs: Community Driven Projects

The final group of projects is the Community Driven category. IDNs will select a total of three Community Driven projects, one from each of the following categories: (1) Care Transition Projects designed to support beneficiaries with transitions from institutional settings into the community; (2) Capacity Building Projects designed to strengthen and expand workforce and program options; and (3) Integration Projects

designed to integrate care for individuals with behavioral health conditions among primary care, behavioral health care and social service providers.

The IDN Community Driven menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through a behavioral health needs assessment and community engagement. As they select and implement community-driven projects, IDNs will have significant flexibility to target key sub-populations; to change the way that care is provided in a variety of care delivery settings and at various stages of treatment and recovery for sub-populations; and to use a range of strategies to change the way care is delivered and connected with social supports.

The Three Project Groups: How Projects Relate to One Another

These six projects are not designed to be implemented in isolation from one another. To the contrary, the projects will be highly interdependent. The three foundational projects will provide the main thrust of transformational change for an IDN, and the three Community-driven projects will allow an IDN to tailor its implementation with particular emphasis given to sub-populations or services that reflect its local community needs.

Many, if not all, of the Community-driven projects selected by the IDNs will have workforce and HIT implications and needs. These should be reflected in the workforce and HIT work undertaken by the IDN through the two statewide projects. Similarly, many, if not all, of the Community-driven projects selected by the IDNs (described further below) will build on the foundational requirements of the Core Competency project (“Integrated Healthcare”) and should be closely coordinated and integrated as part of the implementation process.

As IDNs initiate project selection, planning, and implementation, there are certain guiding principles that should inform the way the individual projects relate to one another and to existing resources and initiatives:

1. *Leverage existing resources.* IDN organizations should leverage opportunities for cross-training of existing staff and redesigning workflows for existing staff in a way that better integrates care planning and communication across different provider types.
2. *Optimize existing beneficiary-provider relationships.* Many providers, including case managers and care coordinators, already have well-established, strong relationships with clients and patients. To the extent it is feasible, IDNs should seek to preserve and optimize these relationships as they implement projects under the transformation initiative. Therefore, for example, if a project requires the addition of care coordination services for a high-risk population, organizations should seek to keep any existing care coordination relationships in place and focus project implementation on ensuring appropriate training for care coordinators and filling gaps in coordination.

3. *Avoid redundancy and duplication.* Implementation of these projects should not promote unnecessary proliferation of providers coordinating care for the same patient. If a patient requires care coordination, there should be one person clearly identified to serve that role. For example, a foundational element of the Integrated Healthcare project is a multi-disciplinary team that includes care coordination/care management resources. If another, more specialized project such as Integrated Treatment for Co-Occurring Disorders requires care coordination, these resources should be rationalized, so that to the extent possible, only one care coordinator/manager is playing a lead role in working with a beneficiary to develop a care plan.

Projects Addressing Substance Use Disorder and Opiate Addiction

New Hampshire is facing a major opioid addiction crisis. One of the driving purposes for the transformation initiative is to provide New Hampshire with additional resources to combat this opioid epidemic and other substance use disorders in coordination with other efforts across the state. The project menu is designed to respond to this pressing need in a variety of different ways, highlighted below. These initiatives are intended to build on and be implemented in concert with efforts already underway across the state to improve SUD prevention, treatment, and recovery, including those coordinated by the Governor's Taskforce on Alcohol and Drug Abuse (e.g., population-level awareness campaigns, changes to prescribing guidelines, targeted prevention interventions, establishment of RPHN Continuum of Care Facilitator and SUD Prevention Coordinator roles).

1. *SUD Provider Workforce Capacity Development.* Given the significant SUD provider capacity shortages in the state and the need for a stronger peer support network, IDNs will be coming together into a Taskforce as part of the Statewide Behavioral Health Workforce Capacity Development project to quantify workforce capacity gaps and identify statewide and local strategies to address them. This Taskforce will include representation from SUD experts within IDNs as well as statewide experts, including representation from the Governor's Taskforce on Alcohol and Drug Abuse. Each IDN will then be required to develop its own IDN-specific workforce capacity development plan, and SUD workforce capacity development will be a required aspect of each plan to receive approval.
2. *Integration of SUD services with mental health and primary care.* As part of the mandatory core competency project, all primary care and behavioral health providers in an IDN will be required to implement a Comprehensive Core Standardized Assessment process that will include the evidence-based SUD screening process Brief Intervention and Referral to Treatment (SBIRT). For individuals with positive screens, all providers will be required to have a multi-disciplinary core team available to support individuals with SUD. In addition, primary care practices with the capacity to do so will be required to adopt Medication Assisted Therapy (MAT) interventions.
3. *SUD-focused Community-Driven projects.* Community-driven projects allow IDNs to tailor implementation with particular emphasis given to sub-populations or services that reflect its local community needs. IDNs will be required to select at least one Community-driven project focused exclusively on the SUD population. These include:

- Medication Assisted Treatment (MAT) of Substance Use Disorders
- Expansion in Intensive SUD Treatment Options, Including Partial-hospital and Residential Care
- Substance Use Treatment and Recovery Program for Adolescents and Young Adults
- Integrated Treatment for Co-Occurring Disorders

In addition, many of the remaining Community-driven projects also address the needs of the SUD population as part of larger initiatives, including the supportive housing project and a project aimed at improving care for people with mental health and/or substance use disorders who are leaving jails and prisons.

Relationship to Other Statewide Initiatives

As previously noted, this transformation initiative is only one of several ongoing initiatives to support New Hampshire's vision for behavioral health reform. New Hampshire's goal is prevention, early diagnosis, and high quality, integrated care provided in the community whenever possible for mental health conditions, opiate abuse, and other substance use disorders (SUD). The initiative is designed to work in concert with other efforts, including:

- Governor's Commission on Alcohol and Drug Abuse
- State Innovation Model (SIM)
- SUD Benefit for Traditional Medicaid Population (July 2016)
- New Hampshire Health Protection Program
- Several ongoing workforce capacity development initiatives
- Establishment of Regional Public Health Network Continuum of Care Facilitators

The State designed the project menu to compliment these existing initiatives, and IDNs should seek to plan and implement projects in a way that aligns with and enhances the ongoing efforts driven by these and other related initiatives.

Project Specifications and Process Milestones

This document provides additional detail and specifications for each of the projects available in the project menu. For each project, the draft specifications contained in this document begin with an overview of the intended project objectives, target patient/client population, and target types of organizations who will likely participate in the project. The specifications then lay out a set of 'Core Project Components.' These reflect the core elements that an IDN must incorporate into its implementation of a project and are typically tied to the evidence-base that supports or informs the project. As long as these core elements are addressed, the IDNs have the flexibility to tailor the implementation of each project to local needs and resource availability.

The specifications also outline the Process Milestones that the IDN will be accountable for meeting in order to earn incentive payments during the four semi-annual reporting/payment periods during 2017-2018. As part of this reporting process, IDNs are required to demonstrate that organizations participating in this project (as identified in the approved IDN Project Plan) have achieved the process milestones described, or in advance of, the timeframes noted. More information on the mechanics and templates for this reporting process will be available as part of the Project Plan development process.

Project Specifications

Project Group A: Statewide Projects
Mandatory for All IDNs

Project Pathway	Statewide
Project ID	A1
Project Title	A1: Behavioral Health Workforce Capacity Development
Project Objective	<p>This project will establish the workforce required to meet the objectives of the DSRIP waiver. 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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>
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 waiver. 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	<p>Phase 1: Form Statewide Behavioral Health Workforce Capacity Taskforce <i>(August-September 2016)</i></p> <p>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</p>

The taskforce will be facilitated by the State or its delegate and be made up of the following representatives:

- One (1) mental health-focused representative from each IDNs
- One (1) SUD-focused representative from each of the IDN's
- Seven (7) additional *specialized* taskforce members with representation across at least seven (7) of the following types of organizations:
 - Primary Care Physicians serving the Medicaid population
 - SUD Providers – including recovery providers, serving the Medicaid population
 - Regional Public Health Networks
 - Community Mental Health Centers
 - Governor's Commission Treatment Taskforce
 - Addiction recovery support services
 - Hospitals
 - Federally qualified health centers, community health centers or rural health clinics
 - Community based organizations that provide social and support services (transportation, housing, employment, community supports, legal assistance, etc.
 - County Organizations
 - School-based organizations

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.

Please see 'Additional Information' section for detail on existing or planned initiatives/data sources.

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 in order to meet the identified requirements

The Strategic Plan will include, at a minimum, measurable outcomes 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

	<p>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.</p>
<p>Process Milestones</p>	<p>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.</p> <p>Key milestones include:</p> <ol style="list-style-type: none"> 1. Phase 1: Participation in formation and kick-off of Statewide Behavioral Health Workforce Capacity Taskforce (Aug-Sept 2016) 2. Phase 2: Workforce data/initiative inventory assessment (Sept-Oct 2016) 3. Phase 3: Participation in Development of Statewide Workforce Capacity Strategic Plan (Oct 2016- Jan 2017) 4. Phase 4: Development, submission, and approval of IDN Workforce Capacity Development Implementation Plan (Jan 2017 – March 2017) 5. Implementation of IDN Workforce Capacity Development Plan; ongoing semi-annual reporting against targets identified in plan
<p>Additional Information related to inventory of existing workforce data, initiatives, and activities</p>	<p>Completed or in-process activities may include, but are not limited to:</p> <ul style="list-style-type: none"> • SUD Core Competencies for Licensed Mental Health Providers (http://www.dhhs.nh.gov/dcbcs/bdas/documents/core-competencies.pdf) • MAT Best Practices (http://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf) • Recommendations for revisions to CRSW requirements (http://www.dhhs.nh.gov/dcbcs/bdas/documents/crsw-comparison-chart.pdf, http://www.dhhs.nh.gov/dcbcs/bdas/documents/proposed-administrative-rules.pdf) • SAMHSA work force development initiative • Training & Technical Assistance Contract - NH Training Institute on Addictive Disorders, Communities of Practice, Technical Assistance • Scholarships for national and regional training events • Peer Recovery Support Services Facilitating Organization RFP (http://www.dhhs.nh.gov/business/rfp/index.htm#peer) • SBIRT Development Initiative in Community Health Centers <p>Agencies/Efforts the Taskforce and IDNs may consider coordinating with include:</p> <ul style="list-style-type: none"> • Regional Public Health Network Continuum of Care Facilitators • Regional Access Points • Governor's Commission Treatment Taskforce

- New Hampshire Children’s Behavioral Health Workforce Development Network

Other relevant activities/initiatives:

- State Loan Repayment Program
- Health Professions Data Center
- Legislative Commission on Primary Care Workforce Issues
- Recruitment Center Contract with Bi-State Primary Care Association
- Collaboration between University of New England College of Osteopathic Medicine North Country Health Consortium
- New Hampshire Children’s Behavioral Health Workforce Development Network Core Competencies training efforts including the FAST Forward System of Care and YouthMOVE peer-to-peer training

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Project Pathway	Statewide Projects
Project ID	A2
Project Title	A2: Health Information Technology (HIT)¹ Infrastructure to Support Integration
Project Objective	<p>See also requirements for Project B-1</p> <p>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 waiver 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).</p> <p>Facilitated by DHHS representatives and/or delegates, this Taskforce will be charged with:</p> <ol style="list-style-type: none"> a) Assessing the current HIT infrastructure gaps across the state and IDN regions b) Coming to consensus on statewide HIT implementation priorities given waiver objectives c) Identifying the statewide and local IDN HIT infrastructure requirements to meet demonstration goals, including: <ol style="list-style-type: none"> i. Minimum standards required of every IDN ii. ‘Desired’ standards that are strongly encouraged but not required to be adopted by every IDN iii. A menu of optional requirements. <p>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.</p> <p>The four DSRIP Waiver objectives driving the HIT infrastructure work are comprehensive and include:</p> <ol style="list-style-type: none"> 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.

¹ The term “Health Information Technology (HIT)” is considered to be inclusive of Health Information Exchange (HIE) as well in this document.

- 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, 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 Advisory². While not every HIT infrastructure gap can be addressed through this demonstration, examples of current gaps that will be considered include:

- 1) Level of IDN participants utilizing ONC Certified Technologies³
- 2) 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.
- 3) Level of IDN participants utilizing Certified Electronic Health Record Technology (CEHRT).
- 4) 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.
- 5) 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.
- 6) 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).
- 7) Ability for IDN participants to use comprehensive, standardized physical and behavioral health assessments.
- 8) 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.
- 9) 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.

² <https://www.healthit.gov/standards-advisory/2016>, the Office of the National Coordinator for Health IT 2016 Interoperability Standards Advisory was published in March 2016.

³ <http://oncchpl.force.com/ehrcert> Downloadable list of all ONC Certified Health IT Product List.

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	<p>Phase 1. Statewide HIT Taskforce: Facilitated Current State Assessment (July 2016 – September 2016)</p> <p><i>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.</i></p> <p><i>Key work steps in this phase include:</i></p> <ol style="list-style-type: none"> 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 a delegate will conduct an updated review of pertinent State and Federal laws re: patient consent and 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 Waiver objectives. <p>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)</p> <p><i>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.</i></p> <p>Alignment goals will center on the following issues which are designed to help close the gaps in HIT that will support the DSRIP Waiver:</p> <ol style="list-style-type: none"> a. Support for achievement of overall DSRIP Waiver goals, within the context of current HIT infrastructure gaps and HIT assessment. Potential statewide and regional priorities could include determination and definition of: <ol style="list-style-type: none"> 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)⁴.
 - 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.

Note: As a condition of receiving DSRIP funding, IDNs must provide the outcome and financial data required by the state to administer the DSRIP waiver. Even prior to completion of the activities outlined above, IDNs will be required to provide the state with the financial and other data required to administer the waiver in a format and on a schedule determined by the state

Phase 3. Individual IDN Task: Develop Future State IDN-Specific Implementation Plans and Implementation 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

⁴ <https://ecqi.healthit.gov/ecqm>

	<p><i>and approved prior to the State authorizing use of DSRIP funds for implementation.</i></p> <ol style="list-style-type: none"> 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 participants⁵. 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 Waiver implementation. <p>Phase 4. Individual IDN Task: Implementation of IDN-specific Plan <i>(September 2017 – December 2018)</i></p> <p>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.</p>
<p>Process Milestones</p>	<ol style="list-style-type: none"> 1) IDN Participation in Statewide HIT Taskforce: Current State Assessment <i>(July 2016 – September 2016)</i> <ol style="list-style-type: none"> 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 <i>(October 2016 – March 2017)</i> <ol style="list-style-type: none"> a. Consensus Meetings Held b. Consensus Report Published

⁵ State designated receiving facilities (DRFs) include: Franklin Hospital, Portsmouth Hospital, Elliott Hospital, and Cypress Center.

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| | <ul style="list-style-type: none">3) Individual IDN Milestone: Develop Future State IDN-Specific Implementation Plans and Timelines (<i>April 2017 – August 2017</i>)<ul style="list-style-type: none">a. IDN Plans Developedb. IDN Submits Draft Planc. State Reviews Draftd. State Communicates Comments on Drafte. IDN Submits Final Planf. State Approves/Denies Plan
4) Individual IDN Milestone: Implementation of IDN-specific Plan (<i>September 2017 – December 2018</i>)<ul style="list-style-type: none">a. Milestones as Defined in Plan |
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Project Group B: Core Competency Project
Mandatory for All IDNs

Project Pathway	Core Competency
Project ID	B1
Project Title	B1: Integrated Healthcare
Project Objective	<p>The integration of care across primary care, behavioral health (mental health and substance misuse/SUD) and social support service providers is a foundational core competency requirement for participants in the demonstration waiver. 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.</p> <p>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.</p>
Target Population	Beneficiaries with behavioral health conditions <i>or at risk for</i> 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
Related Projects	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>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).</p>

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.

***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:

1. Depression screening ,e.g., PHQ 2 & 9
2. Brief intervention and referral to treatment in primary care (SBIRT)

Multi-disciplinary core team

- Multi-disciplinary core team 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 co-located 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), proving 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
- 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:
 - 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.

- 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.
- 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
- Adoption of *both* of the following evidence-based interventions:
 1. Medication-assisted treatment (MAT) in both primary care and specialty care settings
 2. Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., 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)

Additional information and support can be found at:

<http://www.integration.samhsa.gov/about-us/pbhci>

<http://impact-uw.org/>

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

Project Groups C, D, E: Community-driven Projects
IDNs Select One Project from Each Category (three total)

Community Driven Projects: Care Transitions-focused

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Project Pathway	Care Transitions
Project ID	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	<p>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.</p> <p>Key elements of the project include the following:</p> <p>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:</p> <ul style="list-style-type: none"> • 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 • Identifies and meets with existing supports and introduces the client to new supports as needed. <p>Phase 2: The caseworker monitors and strengthens support network and client's self-management skills, assesses support network effectiveness and helps client to makes changes as needed. The caseworker monitors client progress and encourages</p>

	<p>client to increase levels of responsibility.</p> <p>Phase 3: The caseworker completes the termination of CTI services with the client’s support network safely in place.</p> <p>More information can be found at: http://www.criticaltime.org/</p>
<p>Process Milestones</p>	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <ol style="list-style-type: none"> 1. Development of implementation plan, which includes: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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

Project Pathway	Care Transitions
Project ID	C2
Project Title	C2: Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues
Project Objective	<p>Research indicates that significant numbers of adults in correctional facilities and youth in juvenile justice residential facilities have diagnosed and undiagnosed mental illness and/or substance use disorders. Community re-entry is a time-limited program to assist those individuals with behavioral health conditions to safely transition back into community life. The program is initiated pre-discharge and continues for 12 months post discharge. The program’s objectives are to:</p> <ol style="list-style-type: none"> 1. Support adults and youth leaving the state prison, county facilities or juvenile justice residential facilities who have behavioral health issues (mental health and/or substance misuse or substance use disorders) in maintaining their health and recovery as they return to the community. 2. Prevent unnecessary hospitalizations and ED usage among these individuals by connecting them with integrated primary and behavioral health services, care coordination and social and family supports. <p>Note: The objective of this project is to improve care and health outcomes for justice-involved individuals and youth transitioning back into the community, but the State also anticipates that improvements in care will improve public safety and result in a lower recidivism rate.</p>
Target Population	Adults and youth leaving the state prison, county facilities or juvenile justice residential facilities who have behavioral health issues (mental health, SED and/or substance misuse or substance use disorders)
Target Participating Organizations	Any organization identified to participate in supporting care transitions for justice-involved individuals transitioning back into the community (including the Sununu Youth Services Center)
Related Projects	N/A
Project Core Components	<p>Core elements of the community re-entry program include:</p> <ul style="list-style-type: none"> • Screening for Behavioral Health Conditions: Prior to departure, all persons in correctional facilities and juvenile justice facilities will be screened for behavioral health conditions. The facility participating in the initiative will select the screening tool in collaboration with participating IDN partners. It can rely on an existing tool if the tool serves to identify behavioral health conditions and individuals at particularly high risk for relapse. • Discharge Assessment: For individuals with behavioral health conditions, the IDN (or participating partners within

the IDN) will work with the correctional facility or juvenile justice facility to begin assessments, case management and care coordination, treatment planning, family support services, and programming with identified individuals at least 30 days prior to release. This will include a documented core standardized assessment by the care team and a physical exam that becomes the basis for a post-release care plan appropriate for release and/or parole. This plan, described in more below, will be developed in collaboration with the correctional facility/detention center to ensure appropriate linkage of services and needs.

- **Transitional care plan:** Working in collaboration with the correctional facility or juvenile justice facility, the IDN (or participating partners) will develop a goal-oriented transitional care plan with the individual. The care plan is designed to guide the individual and the care team through a successful transition that links the individual to needed community supports and, as appropriate, family supports. It will provide for:
 - Clear identification of the person who is responsible for leading the effort to support the individual's re-entry into the community and family life.
 - Linkage with an integrated care team including primary and behavioral health service providers for treatment, medication management, recovery services and care management, as described in more detail below.
 - Steps that will be taken to connect the individual to community-based social support services as necessary, including:
 - Assistance in securing housing (including supported housing or other housing options for hard-to-place individuals)
 - Training and supported employment aimed at assisting the individual to find employment despite a history of involvement in the justice system
 - Re-engagement and mediation with family members and other care givers
 - Linkages to and enrollment in entitlement programs and other social supports, including, as appropriate, parenting classes.
 - Trained peer support specialists who can work directly with the justice involved person to provide peer mentoring, listening, transportation to services, and/or other forms of support.
 - Completion of releases to allow for secure communication among team members
 - For youth, linkages to family-based supports (including for foster families, as appropriate)
- **Care management services:** The integrated care team will include a care manager who will be in regular contact with individual in person and by phone at decreasing levels of intensity/frequency during the 12 months following release. The care manager will assist in arranging and coordinating medical, behavioral health, family and social

	<p>support services; assist the individual and, for youth, the family, in following the agreed-upon transition plan, including by assisting with adherence to treatment regimen and in securing needed services; and ensure the care plan remains useful and is updated regularly. For adults, the care manager will also serve as a link with parole officers and for children with juvenile justice services.</p> <ul style="list-style-type: none"> • Staffing: The integrated care team will be multi-disciplinary and serve between 25-50 individuals, depending on severity. The staff should include: <ul style="list-style-type: none"> ○ Care manager with Bachelor or Master’s degree in social work or human relations field with training/experience in serving the justice-involved population, including youth and veterans: ○ Mental health professional (e.g., LCSW, Psychologist) who will support and supervise the care coordinator ○ Consulting psychiatrist to design medication regimen and serve as an advisor to the team ○ Primary care provider (PCP) ○ For youth, family support specialists
<p>Process Milestones</p>	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <ol style="list-style-type: none"> 1. Development of implementation plan, which includes: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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, including the Sununu Youth Services Center
- 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

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Project Pathway	Care Transitions
Project ID	C3
Project Title	C3: Supportive Housing
Project Objective	<p>By combining affordable housing with supportive services, this project is designed to assist individuals with a history of homelessness, severe mental illness, substance use disorders or other factors that put them at risk of “ping ponging” between institutions and the community. Its objective is to improve the physical health, behavioral health, successful integration into the community and self-sufficiency of participating individuals, as well as to reduce avoidable readmissions, ED visits, and incarceration due to mental health conditions or substance use disorders. Under the project, IDNs will partner with community housing providers to develop transitional and permanent supportive housing for high risk individuals who otherwise would not be able to successfully transition back into the community or maintain their stability and recovery in the community.</p> <p>Note that the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (DHHS) recognizes permanent supportive housing as an evidence-based program for people with behavioral health conditions (SAMHSA, 2014). To learn more, visit the SAMHSA web site and download the Permanent Supportive Housing Evidence Based Practice (EBP) Kit: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-451.</p> <p>It is important to note that the NH DSRIP Waiver does not allow for the funding of housing costs including rental subsidies, construction costs or “bricks and mortar” funding (see Special Terms and Conditions, Section 60, page 30 of 42). Thus, each IDN must work in collaboration with an appropriate housing agency/resource to identify the affordable housing component of the initiative.</p>
Target Population	Medicaid beneficiaries with significant mental health or substance use disorders that place them at high risk of institutionalization in the absence of supportive housing
Target Participating Organizations	Community-based social service organizations, hospitals, and other institutions that serve the target population (including New Hampshire Hospitals and jails if relevant), community-based mental health and substance use disorder providers and peer support specialists.
Related Projects	This project is closely linked with the workforce development project, which will need to address any staffing requirements associated with the supportive services provided through this project. The population targeted by this project also is likely to be addressed through E6, Integrated Treatment for Co-Occurring Disorders, E7, the Enhanced Care Coordination Project, and D9, the Substance Use Disorder Treatment Capacity Expansion Project.
Project Core	Core components of the supportive housing project include the following:

<p>Components</p>	<ol style="list-style-type: none"> 1. Partnering with one or more housing agencies/resources to develop and implement a supportive housing plan with a transitional and a permanent component. The plan will include: <ul style="list-style-type: none"> • A targeting and priority-setting process to identify individuals with substance use disorder (SUD) and/or mental health conditions who require moderate to intensive housing-based supports to transition to and remain in the community, as well as the basis for establishing priority for service. • A description of the regionally based housing resources that will be used as the platform for the initiative. • A service protocol that identifies the housing related activities and services available through the initiative and how they will be provided, including as appropriate via arrangement with other agencies. Developing transition of care pre tenancy and tenancy sustaining protocols to ensure individuals newly entering or re-entering supportive housing have the appropriate medical, behavioral health, and social services needed to prevent re-institutionalization and promote a safe and stable return to the community. 2. The following housing related activities and services were outlined in the CMS informational bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities dated 6.26.2015 (https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf). The pre tenancy and tenancy sustaining protocols should include the following housing related support services (as appropriate). <ul style="list-style-type: none"> • Conducting a screening and assessment of housing preferences/barriers related to successful tenancy. • Developing an individualized housing support plan based on the assessment. • Assisting with rent subsidy application/certification and housing application processes. • Assisting with housing search process. • Identifying resources to cover start-up expenses, moving costs and other one-time expenses. • Ensuring housing unit is safe and ready for move in. • Assisting in arranging for, and supporting, the details of move-in. • Developing an individualized housing support crisis plan. • Providing early identification/intervention for behaviors that may jeopardize housing. • Education/training on the role, rights and responsibilities of the tenant and landlord. • Coaching on developing and maintaining relationships with landlords/property managers. • Assisting in resolving disputes with landlords and/or neighbors. • Advocacy/linkage with community resources to prevent eviction. • Assisting with the housing recertification process. • Coordinating with tenant to review/update/modify housing support and crisis plan. • Ongoing training on being a good tenant and lease compliance.
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	<ol style="list-style-type: none"> 3. Establishing MOUs or other mechanisms between the IDN and institutions that allow for housing and supportive services staff to meet with individuals in the institutional setting prior to discharge and plan the transition to a supportive housing site. The MOUs will be established with each major institution that serves the population eligible for the IDN’s supportive housing initiative, including New Hampshire Hospital. 4. Developing coordination of care strategies with Medicaid managed care organizations to ensure Medicaid-covered services are in place for the individuals in the supportive housing project, beginning at the time of discharge 5. Ensuring medical records and care plans are transmitted and shared in a timely manner with an individual’s primary care provider and behavioral health providers, as well as other frequently used specialists or community based providers. 6. Evaluating the effectiveness of the supportive housing initiative, including on individuals’ health, housing stability, and successful integration into the community; avoidable hospitalizations and ED visits; health care expenditures; and social service and criminal justice expenditures.
<p>Process Milestones</p>	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <ul style="list-style-type: none"> • Development of implementation plan, which includes: <ul style="list-style-type: none"> ○ Implementation timeline ○ Project budget ○ Work force plan: staffing plan; recruitment and retention strategies ○ Projected annual client engagement volumes ○ Key organizational/ provider participants, including housing agencies/resources • Design and development of clinical services infrastructure, which includes identification or development of: <ul style="list-style-type: none"> ○ Standardized assessment tool(s) ○ Patient assessment, treatment, management, and referral protocols ○ Roles and responsibilities for team members ○ Training plan

- Training curricula
- Agreements with collaborating organizations
- Evaluation plan, including metrics that will be used to measure program impact
- 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

- **Operationalization of program**
 - Implementation of workforce plan associated with this project, if relevant
 - Deployment of training plan
 - Implementation of any required updates to clinical protocols, or other operating policies and procedures
 - Use of assessment , treatment, management and referral protocols
- **Initiation of data reporting**
 - Number of individuals served (during reporting period and cumulative), vs. projected
 - Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - 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**
 - Number of individuals served (during reporting period and cumulative), vs. projected
 - Number of staff recruited and trained (during reporting period and cumulative), vs. projected
 - Staff vacancy and turnover rate for period and cumulative vs projected
 - Impact measures as defined in evaluation plan

Jul-Dec 2018 Reporting Period

- **Ongoing data reporting**

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| | <ul style="list-style-type: none">○ Number of individuals served (during reporting period and cumulative), vs. projected○ Number of staff recruited and trained (during reporting period and cumulative), vs. projected○ Staff vacancy and turnover rate for period and cumulative vs projected○ Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements |
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Community Driven Projects: Capacity Building Focused

Project Pathway	Community Driven: Capacity
Project ID	D1
Project Title	D1: Medication Assisted Treatment (MAT) of Substance Use Disorders
Project Objective	This project seeks to implement evidence based programs combining behavioral and medication treatment for people with substance use disorders, with or without co-occurring chronic medical and/or mental health conditions. IDNs selecting this project will increase access to MAT programs through multiple settings, including primary care offices and clinics, specialty office-based (“stand alone”) MAT programs, traditional addiction treatment programs, mental health treatment programs, and other settings. The goal is to successfully treat more individuals with substance use disorders, for some people struggling with addiction, help sustain recovery.
Target Population	Individuals with substance used disorders with or without co-occurring chronic medical and/or mental health conditions.
Target Participating Organizations	<ul style="list-style-type: none"> Behavioral health, primary care or specialty providers
Related Projects	<ul style="list-style-type: none"> 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)
Project Core Components	<p>Definitions:</p> <ul style="list-style-type: none"> The Federal Substance Abuse Mental Health Services Administration (SAMHSA) defines Medication Assisted Treatment (MAT) as the use of FDA-approved opioid agonist medications (e.g., methadone, buprenorphine products, including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations) for the maintenance treatment of people with opioid use disorder, and opioid antagonist medication (e.g., naltrexone products, including extended-release and oral formulations) in combination with behavioral therapies to prevent relapse to opioid use. MAT is intended to be provided in combination with comprehensive substance use disorder or co-occurring (mental health and substance use) disorders treatment. <p>Implementation requirements for organizations participating in this project include:</p> <ul style="list-style-type: none"> Multidisciplinary MAT teams, including prescribers, nurses, care managers, therapists, and other staff External relationships, as needed, to implement MAT program, such as pharmacies, labs, and organizations that provide ancillary services Provision or facilitation of initial and on-going staff training and supervision related to MAT knowledge and skills Written policies and procedures for MAT program(s)

	<ul style="list-style-type: none"> • Utilization of the Prescription Drug Monitoring Program (PDMP) each time a prescription is written • Compliance with confidentiality requirements including 42CFR part II • Timely communication among the patient, prescriber, counselor, case manager and external providers • Accurate and proper documentation of care (e.g., treatment plans, confidentiality) <p>Core elements of MAT programs implemented by organizations participating in this project include:</p> <ul style="list-style-type: none"> • Screening, and comprehensive core assessment diagnosis (severity of opioid use disorder, physical dependence, co-occurring conditions, and appropriateness for MAT) • Prescription and monitoring of opioid agonist medications based on federal and state guidelines • Case management to coordinate and facilitate patient care and access to additional needed resources • Evidence-based behavioral addiction treatments, such as cognitive behavioral therapy, contingency management, and family intervention • Treatment for all co-occurring substance use disorders, including tobacco use disorder, utilizing behavioral therapies and medications • Treatment for co-occurring mental health disorders with medication and behavioral therapies • Program features to enhance access for: <ul style="list-style-type: none"> ○ Pregnant women ○ Individuals that have experienced an overdose in past 30 days ○ IV drug users ○ Custodial parents of minor children ○ People who are employed <p>All SUD / COD services are required to be in accordance with He-W 513 administrative rules: http://www.dhhs.nh.gov/ombp/nhhpp/documents/hew513-sud-rule.pdf</p> <p>Medication assisted treatment services are outlined in the “Guidance Document on Best Practices: Key Components for Delivery Community-Based Medication Assisted Treatment Services for Opioid Use Disorders In New Hampshire”. http://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf</p>
<p>Process Milestones</p>	<p>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.</p>

Jan-Jun 2017 Reporting Period

- **Development of implementation plan, which includes:**
 - Implementation timeline
 - Project budget
 - Work force plan: staffing plan; recruitment and retention strategies
 - Projected annual client engagement volumes
 - Key organizational/ provider participants

- **Design and development of clinical services infrastructure, which includes identification or development of:**
 - Standardized assessment tool(s)
 - Patient assessment, treatment, management, and referral protocols
 - Roles and responsibilities for team members
 - Training plan
 - Training curricula
 - Agreements with collaborating organizations
 - Evaluation plan, including metrics that will be used to measure program impact. Example measures include:
 - Proportion of MAT patients with urines positive for illicit opioids in first month, 3rd month, 6th month and 12th month of their treatment
 - Proportion of MAT patients with urines positive for prescribed non-MAT opioids in first month, 3rd month, 6th month and 12th month of their treatment
 - Past 6-month number of opioid-related deaths in IDN region
 - 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

- **Operationalization of program**
 - Implementation of workforce plan
 - Deployment of training plan

- Implementation of any required updates to clinical protocols, or other operating policies and procedures
- Use of assessment , treatment, management and referral protocols

- **Initiation of data reporting**

- Number of individuals served through MAT program (during reporting period and cumulative), vs. projected
- Number of MAT program staff recruited and trained (during reporting period and cumulative), vs. projected
- 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**

- Number of individuals served through the MAT program (during reporting period and cumulative), vs. projected
- Number of MAT program staff recruited and trained (during reporting period and cumulative), vs. projected
- MAT program staff vacancy and turnover rate for period and cumulative vs projected
- Impact measures as defined in evaluation plan

Jul-Dec 2018 Reporting Period

- **Ongoing data reporting**

- Number of individuals served through the MAT program (during reporting period and cumulative), vs. projected
- Number of MAT program staff recruited and trained (during reporting period and cumulative), vs. projected
- MAT program staff vacancy and turnover rate for period and cumulative vs projected
- Impact measures as defined in evaluation plan

Project Pathway	Capacity Building
Project ID	D2
Project Title	D2: Expansion of Peer Support Access, Capacity, and Utilization
Project Objective	This project seeks to promote the inclusion of the peer support perspective in behavioral health service planning/delivery, increase collaboration between traditional clinical behavioral health programs and alternative mental health consumer-run peer support agencies, and expand peer support workforce capacity, including peer-run Crisis Respite Centers. It is anticipated that the project will result in improved health status for individuals with behavioral health conditions and reduced use of more restrictive crisis service settings including involuntary hospital admissions.
Target Population	Beneficiaries with behavioral health conditions
Target Participating Organizations	Peer support agencies, organizations with Assertive Community Treatment Teams (ACT) or Mobile Crisis Response Teams (MCRT) Program teams, SUD outpatient programs, and other organizations seeking to expand peer support services.
Related Projects	This project should be implemented in close coordination with Project A1 Behavioral Health Workforce Capacity Development
Project Core Components	<p>IDNs who implement this project are expected to demonstrate progress towards inclusion of peers at various levels within traditional clinical behavioral health service provider organizations, including in paid positions, and inclusion of peer workers in planning and advisory boards where possible.</p> <p>In addition, as part of its Project Plan, IDNs who choose to implement this project will identify the specific participating organizations. Participating organizations are expected to implement the following core project elements.</p> <p>Core elements of the project include:</p> <ul style="list-style-type: none"> • Demonstrated collaboration between traditional clinical behavioral health programs with peer support agencies, defined as mental health, peer-run, independent non-profit organizations • Inclusion of peer workers on Assertive Community Treatment Teams (ACT) and Mobile Crisis Response Teams (MCRT) Program teams • Formal training and supervision of peer workers <ul style="list-style-type: none"> ○ Formal, written peer staff training requirements, and training compliance monitoring and peer staff supported in obtaining required training and monitored for compliance. ○ Support for peer workers in obtaining required training, and where possible, external certifications or accreditations ○ Appropriate peer supervision: supervision of peers in paid positions must include specific job descriptions a

	<p>component of peer to peer supervision or co-supervision.</p> <ul style="list-style-type: none"> • Requirements specific to peer support agencies: <ul style="list-style-type: none"> ○ On-site provision of respite at peer support agencies, as one of many peer-run program offerings ○ 24/7 onsite availability of Peer Support Staff ○ Access to regular activities at peer support agencies during normal business hours. These services will include but not be limited to peer support and wellness activities such as Intentional Peer Support (IPS), Wellness Recovery Action Planning (WRAP), Whole Health Action Planning (WHAM) or equivalent, and a variety of optional offerings such as mindfulness, meditation, nutrition, and social activities ○ Training for Peer Support Agency staff in Intentional Peer Support (IPS) with additional specific training in crisis respite for staff assigned to that program. IDNs implementing this project should also consider YouthMOVE peer-to-peer training and FAST Forward System of Care training specific to children and youth.
<p>Additional Information</p>	<p>Agencies providing peer <i>recovery</i> support services are required to be enrolled in Medicaid as one of three provider types:</p> <ul style="list-style-type: none"> • An SUD Outpatient Program • An SUD Comprehensive Program • A Peer Recovery Program, i.e., a program that is accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or is under contract with the department’s bureau of drug and alcohol services (BDAS) contracted facilitating organization <p>All SUD / COD services are required to be in accordance with He-W 513 administrative rules: http://www.dhhs.nh.gov/ombp/nhhpp/documents/hew513-sud-rule.pdf</p>
<p>Proposed Process Milestones</p>	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <p>7. Development of implementation plan, which includes:</p> <ol style="list-style-type: none"> a. Implementation timeline b. Project budget c. Work force plan: staffing plan; recruitment and retention strategies

- d. Key organizational/ provider participants

8. Design and development of clinical services infrastructure, which includes identification or development of:

- a. Training plan
- b. Training curricula
- c. Agreements with collaborating organizations
- d. Evaluation plan, including metrics that will be used to measure program impact

July-Dec 2017 Reporting Period

9. 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

10. Initiation of data reporting

- a. Number of staff recruited and trained (during reporting period and cumulative), vs. projected
- b. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Jan-Jun 2018 Reporting Period

11. Ongoing data reporting

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

Jul-Dec 2018 Reporting Period

12. Ongoing data reporting

- a. Number of staff recruited and trained (during reporting period and cumulative), vs. projected

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| | <ul style="list-style-type: none">b. Staff vacancy and turnover rate for period and cumulative vs projectedc. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements |
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Project Pathway	Community-driven: Capacity Building
Project ID	D3
Project Title	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	<ul style="list-style-type: none"> • Individuals with substance use disorders (with or without co-occurring mental health disorders) • Within the target population, priority populations include: <ul style="list-style-type: none"> ○ 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	<ul style="list-style-type: none"> • 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) • Project E6 (Integrated Treatment for Co-Occurring Disorders), which focuses specifically on individuals with co-occurring SUD and mental health conditions • 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 D1 (Medication Assisted Treatment of SUD)
Project Core Components	<p>IDNs implementing this project will expand capacity to deliver the following three types of SUD treatment/recovery services.</p> <ol style="list-style-type: none"> 1. At least 1 higher intensity service: <ul style="list-style-type: none"> ○ Intensive Outpatient (IOP) ○ Partial Hospitalization (PH) ○ Non-hospital based residential treatment services <p>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</p>

	<p>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.</p> <p>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.</p>
<p>Process Milestones</p>	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <p>1. Development of implementation plan, which includes:</p> <ul style="list-style-type: none"> 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 <p>2. Design and development of clinical services infrastructure, which includes identification or development of:</p> <ul style="list-style-type: none"> 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	<p>Additional information on the treatment of substance use and co-occurring disorders can be found at:</p> <ul style="list-style-type: none"> • The Substance Abuse Mental Health Services Administration (SAMHSA) 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) are available at: http://store.samhsa.gov/list/series?name=Technical-Assistance-

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Project Pathway	Capacity Building
Project ID	D4
Project Title	D4: Multidisciplinary Nursing Home Behavioral Health Service Team
Project Objective	<p><i>Background</i></p> <p>Nursing home staff have extensive expertise on the physical needs of residents and dementia, however they often do not have access to specialized geriatric-psychiatric expertise and staff required to treat and manage residents who have significant mental illness. Approximately 34 percent of New Hampshire nursing home residents have a mental illness, defined as schizophrenia, dementia, bipolar disorder, depression or anxiety, according to a 2005 study. As a result, nursing homes sometimes admit residents experiencing significant symptoms to inpatient care, including at New Hampshire Hospital, and these residents could continue to be served in the nursing home if additional resources were available.</p> <p><i>Objective</i></p> <p>This project aims to provide nursing homes with additional resources to effectively treat and manage this population through the use of multi-disciplinary care teams for residents with mental health conditions. By providing additional expertise and support in the nursing home setting on mental illness, the project is expected to reduce ED and hospital visits and/or length of stays in the hospital by nursing home residents.</p>
Target Population	Nursing home residents with significant mental illness
Target Participating Organizations	Nursing homes and other collaborating providers
Related Projects	N/A
Project Core Components	<p>IDNs will establish multi-disciplinary behavioral health teams in collaboration with their participating county nursing homes. Funding for the teams and for training costs will be provided by the IDNs.</p> <ul style="list-style-type: none"> • Members of the team will include a primary care physician affiliated with the nursing home, advanced practice nurse with psychiatric training or other behaviorist, a case worker or care manager and consulting psychiatrist with geriatric-specific expertise who is present on site at least 7 hours/week and on call as needed. • At their option, an IDN and participating nursing home can contract with a state or regional-level resource for the geriatric-specific psychiatric expertise required for multidisciplinary teams. • The multidisciplinary teams will provide the following, building on the existing staffing and infrastructure in the nursing home. <ul style="list-style-type: none"> o Psychiatric and medication evaluation, monitoring and treatment o Medical evaluation, monitoring and treatment

	<ul style="list-style-type: none"> o Multidisciplinary treatment planning o Case Management o Individual, group and family interventions o Relapse prevention/recovery services o Leisure and recreational activities o Care coordination during transitions to and from inpatient hospital settings <p>Other project core components include:</p> <ul style="list-style-type: none"> • IDN-supported training/education of multidisciplinary team members and related staff in nursing homes on geriatric-specific psychiatric issues, behavior management, and recovery support. • IDN-supported general educational programs (inclusive of Mental Health First Aid Training) available for all nursing home staff, with the sponsorship and support of the in-house multidisciplinary team, to improve the ability of the general staff to identify, treat, and manage behavioral health problems.
Process Milestones	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <p>7. Development of implementation plan, which includes:</p> <ul style="list-style-type: none"> 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 <p>8. Design and development of clinical services infrastructure, which includes identification or development of:</p> <ul style="list-style-type: none"> a. Standardized assessment tool(s) b. Roles and responsibilities for team members c. Training plan

- d. Training curricula
- e. Agreements with collaborating organizations, 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

July-Dec 2017 Reporting Period

9. 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

10. 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

11. 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

12. Ongoing data reporting

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| | <ul style="list-style-type: none">a. Number of individuals served (during reporting period and cumulative), vs. projectedb. Number of staff recruited and trained (during reporting period and cumulative), vs. projectedc. Staff vacancy and turnover rate for period and cumulative vs projectedd. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements |
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Community Driven Projects: Integration-focused

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Project Pathway	Community-driven: Integration
Project ID	E1
Project Title	E1: Wellness programs to address chronic disease risk factors for SMI/SED populations
Project Objective	Individuals with severe mental illness (SMI) or serious emotional disturbances (SED) commonly experience obesity, tobacco addiction, and other risk factors for the development of diabetes, heart and blood vessel diseases, and cancers leading to high disease burden and early mortality. This project involves the implementation of wellness programs that address physical activity, eating habits, smoking addiction, and other social determinants of health for adolescents with SED and adults with SMI through evidence-informed interventions, health mentors/coaches. These programs are aimed at reducing risk factors and disease burden associated with co-morbid chronic diseases, as well as reductions in preventable hospitalizations and Emergency Room visits.
Target Population	Adults with SMI and adolescents with SED, who are overweight or obese and/or use tobacco.
Target Participating Organizations	<ul style="list-style-type: none"> • Community-based organizations providing services related to health and wellness, exercise, nutrition, and freedom from smoking • Other community-based organizations providing services addressing the social determinants of health • Behavioral health providers • Primary care providers
Related Projects	N/A
Project Core Components	<p>Key elements of wellness programs to be implemented as part of this project:</p> <ul style="list-style-type: none"> • Service provision by a health mentor/coach who has training in coaching for fitness, nutrition and tobacco cessation. Services provided by health mentor/coach will include: <ul style="list-style-type: none"> ○ Development of an individualized, client-centered wellness assessment that addresses physical activity, nutrition and tobacco use ○ Development of an individualized fitness and diet plan reflecting client goals ○ Development of an individualized plan to address tobacco use that incorporates harm reduction and use of evidence-based tobacco cessation counseling (including referral to the Quitline), nicotine replacement therapy, and other medications ○ Teaching of new skills, facilitation of goal setting, and incorporation of motivational strategies to enable immediate and long term behavior change • Weekly contact between client and health mentor/coach, with feedback from the health mentor/coach focusing on wellness activities and reinforcement of exercise, diet modification, smoking reduction/cessation

	<ul style="list-style-type: none"> • Client participation in monthly group sessions on diet and weight management • Facilitated access to local gym membership • Availability of a support group for program clients to share ideas, celebrate successes, and work to overcome obstacles <p>IDNs implementing this project may base its wellness interventions on the approaches of the following evidence-informed programs:</p> <ul style="list-style-type: none"> • InSHAPE • National Diabetes Prevention Program • Diabetes Self-Management Program • Bright Futures • Dimensions Tobacco Free Toolkit for Healthcare Providers
Process Milestones	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <p>13. Development of implementation plan, which includes:</p> <ol style="list-style-type: none"> a. Implementation timeline b. Project budget c. Work force plan for health mentors/coaches: staffing plan; recruitment and retention strategies d. Projected annual client engagement volumes e. Key organizational/ provider participants, including community-based organizations providing services related to health and wellness, exercise, nutrition, and freedom from smoking <p>14. Design and development of clinical services infrastructure, which includes identification or development of:</p> <ol style="list-style-type: none"> a. Standardized wellness assessment tool(s) b. Standardized tools to support the development of client-centered plans fitness/nutrition/tobacco cessation plans c. Roles and responsibilities for health mentors/coaches and other program participants

- d. Training plan for health mentors/coaches
- e. Training curricula for health mentors/coaches
- f. Agreements with collaborating organizations, including community-based organizations providing services related to health and wellness, exercise, nutrition, and freedom from smoking
- g. Evaluation plan, including metrics that will be used to measure program impact (examples include: body mass index, breath carbon monoxide, number of gym visits per month by enrolled clients, number of clients using nicotine replacement therapy)
- h. Mechanisms to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

July-Dec 2017 Reporting Period

15. Operationalization of program

- a. Implementation of workforce plan and hiring of health mentors/coaches
- b. Deployment of training plan for health mentors/coaches
- c. Initiation of client enrollment
- d. Use of standardized assessment and planning tools

16. 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

17. 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

	<p>d. Impact measures as defined in evaluation plan</p> <p><u>Jul-Dec 2018 Reporting Period</u></p> <p>18. Ongoing data reporting</p> <ul style="list-style-type: none"> 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
<p>Additional Information</p>	<p>More information can be found at:</p> <p>http://www.cdc.gov/diabetes/prevention/index.html</p> <p>http://patienteducation.stanford.edu/programs/cdsmp.html</p> <p>www.integration.samhsa.gov/health-wellness-strategies/tobacco-cessation-2smokingcessationleadership.ucsf.edu/behavioral-health</p>

Project Pathway	Community-based: Integration
Project ID	E2
Project Title	E2: School-based Screening and Intervention
Project Objective	This project seeks to build the knowledge and skills of school-based staff to recognize children at-risk-of or in need of mental health or substance use services and to link them with the IDN's community-based provider network, avoiding unnecessary referral to the emergency department and taking full advantage of schools as a key point of entry in a 'no wrong door' approach to identification and effective management of behavioral health risks/conditions. By equipping school-based staff to act as the first line of support for positive outcomes, the project is anticipated to result in improved diagnosis of and early intervention/treatment for the mental health and substance use disorder problems of children and adolescents.
Target Population	Children and adolescents with, or risk of developing, mental health or substance misuse problems
Target Participating Organizations	<p><i>School districts:</i> in order to maximize project impact, IDNs are encouraged to engage its school districts as partners and to include all schools within a given district in the project</p> <p><i>School system staff:</i> school nurses, social workers, guidance counselors, behavioral interventionists, school resource officers, 504 teams, IEP team members, teachers, school psychologists and administrators employed directly by the school system</p> <p><i>Other IDN providers:</i> pediatric health care professionals, mental health providers, SUD providers</p> <p><i>Early intervention program providers, if applicable.</i></p>
Related Projects	Project E3 (Substance use Treatment and Recovery Program for Adolescents and Young Adults)
Project Core Components	<p>This project involves the implementation of an evidence based model, or models, for:</p> <ul style="list-style-type: none"> • Depression screening and follow-up • Screening, brief intervention, and referral to treatment (SBIRT) specific to children and adolescents in a school setting, for use in reducing and preventing problematic use, abuse, and dependence on alcohol and illicit drugs <p>IDNs must develop these models and select the appropriate screening/assessment tools in collaboration with (and with the full support of) the school districts.</p> <p>The project includes the following core elements:</p> <ul style="list-style-type: none"> • Designation of a School Intervention Team composed of selected members of the school staff • Development and deployment of education/training curricula for <i>identified school-based staff</i> to strengthen skills in: <ul style="list-style-type: none"> Screening and prevention <ul style="list-style-type: none"> ○ The use of evidence based screening tools (CRAFFT, GAAD7, PHQ2, PHQ9) and intervention techniques such as

	<p>motivational interviewing to engage the students in the care process</p> <ul style="list-style-type: none"> ○ Identifying indicators of mental health and/or substance misuse issues at varying levels of acuity, and the appropriate interventions ○ Identifying and implementing prevention strategies for students at risk of developing mental health or substance use problems ○ Other tools like the Pediatric Symptom Checklist (PSC – ages 4-16)) or the Child and Adolescent Needs and Strengths Assessment-Mental Health (CANS-MH – ages birth to adolescence) might also be considered as additional effective screening tools. <p>Brief Intervention (for substance misuse)</p> <ul style="list-style-type: none"> ○ Conducting brief interventions with students identified through the evidence-based screening process using motivational interviewing and other identified interventions during the sessions with students ○ Encouraging students to learn more about consequences of substance misuse, understand why they use alcohol and/or drugs, and set goals for changing their behaviors. <p>Referral to Treatment</p> <ul style="list-style-type: none"> ○ Properly referring children and adolescents with higher acuity needs to professionals for evaluation and treatment services <ul style="list-style-type: none"> ● Development of written agreements that include referral protocols for professional evaluation and treatment services including: <ul style="list-style-type: none"> ○ Referral criteria ○ Prompt service access standards for intake and follow up services ○ Joint care planning and communication between School Intervention Team member and providers ○ Appropriate parent /guardian communication & consent ○ Scope of services
<p>Proposed Process Milestones</p>	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <p>1. Development of implementation plan, which includes:</p>

- a. Implementation timeline
- b. Project budget
- c. Work force plan: staffing plan; recruitment and retention strategies (if applicable)
- d. Projected annual client engagement volumes
- e. Key organizational/ provider participants (including school districts and schools)

2. Design and development of clinical services infrastructure, which includes identification or development of:

- a. Selected standardized depression and substance use screening tool(s)
- b. Brief intervention protocol that is specific to youth and children (for SBIRT)
- c. Patient assessment, treatment, management, and referral protocols
- d. Roles and responsibilities for School Intervention Team members and other key program participants
- e. Training plan, including plan for training of Student Intervention Team
- f. Training curricula, including plan for training of Student Intervention Team
- g. Referral/service agreements with collaborating organizations, including referral protocols for professional evaluation and treatment services
- h. Evaluation plan, including metrics that will be used to measure program impact
- i. Mechanisms to track and monitor individuals served by and referred 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, including training of School Intervention Team
- c. Implementation of any required updates to operating policies and procedures
- d. Use of screening, assessment, intervention, and referral protocols

4. Initiation of data reporting

- a. Number of screenings conducted, vs. projected
- b. Number of students activated for brief interventions
- c. Number of students referred to treatment outside the brief intervention scope of service

- d. Number of trained school staff, by school district and school that are engaged in school-based screening and intervention program, 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

5. Ongoing data reporting

- a. Number of screenings conducted, vs. projected
- b. Number of students activated for brief interventions
- c. Number of students referred to treatment outside the brief intervention scope of service
- d. Number of trained school staff, by school district and school that are engaged in school-based screening and intervention program, vs projected
- e. Impact measures as defined in evaluation plan

Jul-Dec 2018 Reporting Period

6. Ongoing data reporting

- a. Number of screenings conducted, vs. projected
- b. Number of students activated for brief interventions
- c. Number of students referred to treatment outside the brief intervention scope of service
- d. Number of trained school staff, by school district and school that are engaged in school-based screening and intervention program, vs projected
- e. Number of individuals served (during reporting period and cumulative), vs. projected
- f. Staff vacancy and turnover rate for period and cumulative vs projected
- g. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Project Pathway	Capacity Building
Project ID	E3
Project Title	E3: Substance Use Treatment and Recovery Program for Adolescents and Young Adults
Project Objective	<p><i>Background</i></p> <p>The 2014 Behavioral Health Barometer published by SAMHSA reports that Illicit drug use, binge drinking, and cigarette use by adolescents (12-17) is higher in New Hampshire than in the United States as a whole. Nearly 5% of NH adolescents took pain relievers for non-medical purposes in 2014 and 14% initiated alcohol use each year between 2012 and 2014. NIDA reports that only ~ 10% of 12-17 year olds needing substance use treatment receive services, and the largest number of those that do are referred by the justice system.</p> <p><i>Objective</i></p> <p>The goal of this project is to expand IDN capacity to deliver effective services that have been shown to reduce substance misuse and risky behaviors among adolescents and young adults that lead to involvement in the justice system, long term or even life-long misuse of illicit drugs, opioids and alcohol. The project calls for IDNs to deploy a set of evidence-based interventions shown to be effective in helping adolescents and young adults to avoid risky behaviors, to treat and support them and their families and care givers in ongoing recovery and preventing relapse. The project identifies a variety of evidence-based interventions in a variety of settings and formats that lead to abstinence, full recovery and restoration to a healthy lifestyle.</p>
Target Population	Adolescents and Young adults 12-21 years old who misuse substances or are at risk of misusing substances including opioids, alcohol, illicit drugs, inhalants and tobacco
Target Participating Organizations	Primary care or behavioral health organizations seeking to expand substance use treatment and recovery services for adolescents and young adults
Related Projects	E2 (School-based Screening and Intervention)
Project Core Components	<p>IDNs will select organizations to participate in this project. Participating organizations will implement the following core project elements:</p> <p><i>Expansion of capacity to deliver treatment/intervention services</i></p> <ul style="list-style-type: none"> • Program interventions should include, where feasible, both outpatient and residential options and medically-managed 24 hour primary medical care programs for most severely affected individuals • Depending on the IDN's community needs assessment findings, evidence-based program approaches may include but are not limited to: <ul style="list-style-type: none"> ○ Stabilization and detoxification programs for youth in crisis ○ Individual and group therapy that employs Cognitive Behavioral Therapy, brief intervention/motivational interviewing and contingency management reinforcement approaches.

- Family Based Therapies, which may include
 - Multi-Dimensional Family Therapy
 - Adolescent Community reinforcement approach (A-CRA)/Assertive Continuing Care (ACC)
 - ARISE model
- Adolescent-specific 12 step program
- Methods to ensure ongoing monitoring of drug use during treatment to ensure early identification of relapse and speedy initiation of treatment.

Expansion of screening and assessment

- Use of standardized screening tools by pediatricians, dentists, emergency room doctors, psychiatrists and other clinicians to determine misuse or risky use as well as depression and anxiety disorders ADHD or other mental health disorders.
- Use of comprehensive assessment tool that is tailored to the target population. The tool should consider the individual's psychological development, gender, family and peer relationships, performance and behavior in school, cultural and ethnic factors and special considerations.
- The screening and assessment should be accompanied by:
 - Brief intervention or referral to treatment programs, as appropriateAn individualized care plan developed with the individual and family members that incorporates a set of interventions and the care team including the PCP and social support services that

For additional information, please refer to:

<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>

<p>Process Milestones</p>	<p><u>Jan-Jun 2017 Reporting Period</u></p> <ol style="list-style-type: none"> 1. Development of implementation plan, which includes: <ol style="list-style-type: none"> a. Implementation timeline b. Project budget c. Work force plan: staffing plan; recruitment and retention strategies as applicable 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: <ol style="list-style-type: none"> a. Selection /development of standardized comprehensive health assessment , and screening tools, care plan template and other tools as needed, applicable to adolescents and young adults b. Assessment, treatment, management protocols for target-population c. Referral protocols including to those to/from PCPs, BH providers, social service support providers and Hospitals, EDs d. Roles and responsibilities for staff in selected interventions e. Training plan for each staff role f. Training curricula for staff role g. Agreements with collaborating providers and organizations forexample referral protocols, coverage schedules, consultant report turnaround time as appropriate h. 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 i. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements 3. Operationalization of program <ol style="list-style-type: none"> 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 <ol style="list-style-type: none"> a. Number of target population of Medicaid beneficiaries receiving comprehensive assessment (during reporting period and cumulative), vs. projected b. Number of target population Medicaid beneficiaries scoring positive on screening tools
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- c. Number of new staff positions recruited and trained (during reporting period and cumulative), vs. projected
- d. Impact indicator 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 target population Medicaid beneficiaries receiving comprehensive assessment during reporting period and cumulative), vs. projected
- b. Number of target population Medicaid beneficiaries scoring positive on screening tools
- c. Number of target population Medicaid beneficiaries scoring positive on screening tools who were referred and had at least X visits in X months period?
- 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

6. Ongoing data reporting

- a. Number of target population Medicaid beneficiaries served (during reporting period and cumulative), vs. projected
- e. Number of target population Medicaid beneficiaries scoring positive on screening tools
- a. Number of target population Medicaid beneficiaries scoring positive on screening tools who were referred and had at least X visits in X months period?
- f. Number of new positions recruited and trained (during reporting period and cumulative), vs. projected
- g. New staff position vacancy and turnover rate for period and cumulative vs projected
- h. Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Project Pathway	Community-based: Integration
Project ID	E4
Project Title	E4: Integrated Treatment for Co-Occurring Disorders
Project Objective	This project involves the implementation of an evidence-based multi-disciplinary program combining substance use disorder (SUD) treatment and mental health (MH) treatment for people with severe mental illness (SMI) using 'stages of change/treatment' approach along with pharmacological and psychosocial therapies and holistic program supports. Research on integrated dual disorder treatment indicates that outcomes resulting from programs that meet fidelity standards include: stable remission of substance abuse, reduction in hospitalization, decrease in psychiatric symptoms and arrests. Also, housing stability, functional status and quality of life are found to improve.
Target Population	Individuals with co-occurring SUD and severe mental illness diagnoses
Target Participating Organizations	<ul style="list-style-type: none"> • Mental health and SUD providers, including integrated treatment specialists • Primary care providers • Coordination with community-based social service organizations • Developmentally Disabled (DD) population Aged Blind and Disabled (ABD) population with co-occurring behavioral health disorders
Related projects	<ul style="list-style-type: none"> • 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) • 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)
Project Core Components	<p>Integrated Treatment for Co-Occurring Disorders is an evidence based treatment program that is built upon seven principles:</p> <ol style="list-style-type: none"> 1. SUD and MH treatment is integrated to meet the needs of clients 2. Treatment specialists are trained in treatment of both SUD and serious mental illness 3. Treatment uses 'stages of change' approach; providers work with people who are actively using alcohol and drugs with active and persistent engagement and motivational strategies 4. Motivational techniques are used throughout the process 5. Cognitive Behavioral Therapy (CBT) is used in substance abuse and mental illness counseling, ideally with group therapy approaches that enhance peer support and role modeling 6. Multiple treatment formats are made available to clients and their family or supports 7. Addiction and mental health medication services are integrated into the psychosocial services <p>Programs following this approach should include the following key elements:</p>

	<p><i>Multi-disciplinary team</i></p> <ul style="list-style-type: none"> • Multi-disciplinary care team that includes integrated treatment specialists, case managers, psychiatrists, nurses, PCP, others as needed • Coordination of care with primary care and social services • 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 <p><i>Robust training and on SUD and serious mental illness</i></p> <ul style="list-style-type: none"> • Training program for treatment specialists based on SAMHSA model for training frontline staff in Integrated Treatment for Co-Occurring Disorders <p><i>Assessment and intervention</i></p> <ul style="list-style-type: none"> • Standardized, ongoing comprehensive core assessment and treatment planning using 'stages of change' treatment approach, which matches interventions to states of change to help clients achieve skills to manage both illnesses in service of achieving personal goals (example intervention techniques: assertive outreach, motivational interviewing, social skills training, cognitive behavioral therapy, groups) • An integrated treatment plan, which identifies the responsible supportive care team member for each goal • Assistance with obtaining and maintaining safe and stable housing • Use of supported employment • Relapse prevention approaches for clients who achieve abstinence • Access to treatment formats targeted at families/supports of clients, including education, family therapy, and support groups <p><i>Technology support</i></p> <ul style="list-style-type: none"> • Use of electronic care coordination/management system to actively coordinate and monitor care among providers and the ability to share patient information among medical, behavioral health and social service providers. • Established closed loop referral system among behavioral health, primary care and community based social support service agencies.
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: staffing plan; recruitment and retention strategies
- d. Projected annual client engagement volumes
- e. Key organizational/ provider participants, including behavioral health providers and community based social support service providers

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 multi-disciplinary team members
- d. Training and supervision plan, conforming to the SAMHSA 'Training Frontline Staff' in Integrated Treatment for Co-Occurring Disorders
- e. Training curricula,
- f. Agreements with collaborating organizations, including community based social support service providers
- g. Evaluation plan, including metrics that will be used to measure program impact and Integrated Dual Disorder Treatment Fidelity Scale (e.g., % controlling symptoms of schizophrenia, % actively attaining remissions from substance abuse, % in independent living situations, % competitively employed, % with regular social contacts with non-substance misusers, number of enrolled clients with emergency department visits and hospitalizations for Behavioral Health and addiction conditions during the reporting period)
- 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 enrolled (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

Project Pathway	Community-based: Integration
Project ID	E5
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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Primary care providers • Behavioral health providers (mental health and SUD) • Community-based social support service organizations
Related Projects	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • IDNs implementing this project will define its specific care coordination models and exact target populations; however, core required elements of any model include: <ul style="list-style-type: none"> ○ Identified care teams that include care coordinator/managers, primary care providers, behavioral health providers ○ Systematic strategies to identify and intervene with target population ○ A comprehensive core assessment and a care plan for each enrolled patient, updated on a regular basis ○ 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 ○ Transitional care coordination across settings, including from the hospital to the community

	<ul style="list-style-type: none"> ○ Technology-based systems to track and share care plans and to measure and document selected impact measures ○ Robust patient engagement process around information sharing consent ○ 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
Process Milestones	<p>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.</p> <p><u>Jan-Jun 2017 Reporting Period</u></p> <ol style="list-style-type: none"> 1. Development of implementation plan, which includes: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. Description of target population and eligibility criteria, including rationale for intervention with this target population that aligns with the goals of the Transformation Waiver b. Standardized assessment tool(s) c. Patient assessment, treatment, management, and referral protocols, including: <ol style="list-style-type: none"> 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

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Outcome Metric Specifications

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Overview of Outcome Metrics

Over the course of the 5-year transformation initiative, the state will shift accountability from a focus on rewarding achievement of process milestones in the early years (2017-2018), to rewarding improvement on performance outcome metrics in the later years (2019-2020). The process milestones for each project are described earlier in this document in the “Process Milestones” section of each project description.

The table below provides the *outcome metrics* that the state will use to measure and reward improvement. The state will measure IDN improvement on these outcome metrics from a baseline. Each IDN will have its own baseline starting point, based on historical data that will be established as soon as complete data is available for the baseline period. The state will set annual improvement targets that reflect consistent annual IDN progress towards closing the gap between the baseline performance of each IDN and a specified performance goal. These performance goals will be based on the 75th – 100th percentile of performance within the state, a comparable national benchmark, or an alternative method approved by the state and CMS.

Additional information regarding outcome metrics, baseline measurement, and performance goals will be available as part of the IDN Project Plan development process.

Table 1: Transformation Initiative Outcome Metrics

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Periodicity	Statewide measure? ⁶	Active Year(s) ⁷				Associated Projects
						2017	2018	2019	2020	
Follow-up After ED Visit or Hospitalization	Readmission to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for Adult 18+ BH Population	HEDIS	IDN; Claims/Encounters and Non-Claim Discharges from NHH for age 21-64	Annual	X	-	-	P4P	P4P	B1,C1,C2,C3, D1,D3,D4,E3,E4,E5
Follow-up After ED Visit or Hospitalization	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - within 30 days	Proposed 2017 HEDIS measure	DHHS; Claims/Encounters	Annual		-	-	P4P	P4P	B1,C1,C2,C3, D1, D2, D3,E3,E4,E5
Follow-up After ED Visit or Hospitalization	Follow-Up After Emergency Department Visit for Mental Illness - within 30 days	Proposed 2017 HEDIS measure	DHHS; Claims/Encounters	Semi-Annually		-	-	P4P	P4P	B1,C1,C2,C3,D2, D4,E4,E5
Follow-up After ED Visit or Hospitalization	Follow-up after hospitalization for Mental Illness – within 30 days	HEDIS 2015 (w/Addition of IMD discharges)	DHHS; Claims/Encounters/ NHH Discharge Data	Annual		-	P4P	P4P	P4P	B1,C1,C2,C3,D4,E4,E5
Follow-up After ED Visit or Hospitalization	Follow-up after hospitalization for Mental Illness – within 7 days	HEDIS 2015 (w/Addition of IMD discharges)	DHHS; Claims/Encounters/ NHH Discharge Data	Annual		-	P4P	P4P	P4P	B1,C1,C2,C3,D4,E4,E5

⁶ Statewide measures denote measures for which the state is accountable for achieving statewide performance targets. A portion of the total statewide funding amount is at risk based on this performance.

⁷ "P4R = Pay for Reporting"; "P4P = Pay for Performance"

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Periodicity	Statewide measure? ⁶	Active Year(s) ⁷				Associated Projects
						2017	2018	2019	2020	
Integration and Core Practice Competencies	Percent of patients screened for alcohol or drug abuse in the past 12 months using an age appropriate standardized alcohol and drug use screening tool AND if positive, a follow-up plan is documented on the date of the positive screen age 12+	DHHS Measure patterned off NQF #0418	IDN; IDN EHR Output	Annual		-	P4R	P4P	P4P	B1,C1,C2,C3, D1, D2, D3,E3,E4,E5
Integration and Core Practice Competencies	Timely Electronic Transmission of Transition Record (Discharges From an Inpatient Facility in IDN (including rehab and SNF) to Home/Self Care or Any Other Site of Care)	CMS Adult Core Set CTR	IDN; IDN EHR Output	Semi-Annually		-	P4R	P4P	P4P	All
Patient Reported Experience of Care	Global Score for Mini-CAHPS Satisfaction Survey at IDN Level (including integration; access to care; baseline 2017) for kids and adults	Subset of CAHPS questions	DHHS; DHHS Mini-CAHPS Survey	Annual		-	P4P	P4P	P4P	B1,D4
Physical Health/Primary Care Clinical Quality/Screening and Assessment	Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers	DHHS Measure	IDN; IDN EHR Report	Semi-Annual	X	-	P4R	P4P	P4P	B1,C1,C2, D1,E3,E4,E5
Physical Health/Primary Care Clinical Quality/Screening and Assessment	Global score for selected general HEDIS physical health measures, adapted for BH population	HEDIS (adapted)	IDN/DHHS; Claims/Encounters/ IDN EHR Report	Annual		-	P4R	P4P	P4P	B1,C1, C2 D1, D2, D4,E1,E3,E4

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Periodicity	Statewide measure? ⁶	Active Year(s) ⁷				Associated Projects
						2017	2018	2019	2020	
BH Care Clinical	Global score for selected BH-focused HEDIS measures	HEDIS	IDN/DHHS; Claims/Encounters/ IDN EHR Report				P4P	P4P	P4P	
Physical Health/Primary Care Clinical Quality/Screening and Assessment	Percent of BH Population With All Recommended USPSTF A&B Services	HEDIS (+)	IDN; Claims/Encounters/ IDN EHR Report	Annual		-	P4P	P4P	P4P	B1,D4
Physical Health/Primary Care Clinical Quality/Screening and Assessment	Recommended Adolescent (age 12-21) Well Care visits	HEDIS (adapted)	DHHS; Claims/Encounters & IDN EHR Report	Annual		-	P4P	P4P	P4P	B1,E2, E3
Physical Health/Primary Care Clinical Quality/Screening and Assessment	Smoking and tobacco cessation counseling visit for tobacco users (CPT codes 99406-99407)	NQF	IDN; IDN EHR Report	Semi-Annual		-	P4R	P4P	P4P	All
Population Level Utilization	Frequent (4+ per year) ER Visits Users for BH Population	DHHS Measure	DHHS; Claims/Encounters	Semi-Annual		-	P4P	P4P	P4P	All
Population Level Utilization	Potentially Preventable ER Visits for BH Population and Total Population	DHHS Measure	DHHS; Claims/Encounters	Semi-Annual	X	-	P4P	P4P	P4P	All
Population Level Utilization	Rate per 1,000 of people without cancer receiving a daily dosage of opioids greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer.	PQA	DHHS; Claims/Encounters	Semi-Annual		-	P4P	P4P	P4P	B1,C1,C2,C3, D1, D2, D3,E3,E4,E5

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Periodicity	Statewide measure? ⁶	Active Year(s) ⁷				Associated Projects
						2017	2018	2019	2020	
Workforce Capacity	Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	HEDIS 2015	DHHS; Claims/Encounters	Annual		-	-	P4P	P4P	B1,C1,C2,C3, D1, D2, D3,E3,E4,E5
Workforce Capacity	Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	HEDIS 2015	DHHS; Claims/Encounters	Annual	X	-	-	P4P	P4P	B1,C1,C2,C3, D1, D2, D3,E3,E4,E5
Workforce Capacity	Percent of new patient call or referral from other provider for CMHC intake appointment (90801 HO) within 7 calendar days	DHHS Measure	DHHS; Phoenix	Semi-Annual		-	-	P4P	P4P	B1,C2,C3,E5
Workforce Capacity	Percent of new patients where intake to first follow-up visit was within 7 days after intake	DHHS Measure	DHHS; Phoenix	Semi-Annual		-	-	P4P	P4P	B1,C1, C2,C3,E5
Workforce Capacity	Percent of new patients where intake to first psychiatrist visit was within 30 days after intake	DHHS Measure	DHHS; Phoenix	Semi-Annual		-	-	P4P	P4P	B1,C1,C2,C3,E5