DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

State Demonstrations Group JUL 20 2016

Deborah Fournier
Interim Director
Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Dear Ms. Fournier:

This letter is to inform you that New Hampshire's submission of the Delivery System Reform Incentive Payments (DSRIP) Planning Protocol and Project Metrics & Specification Guide (Attachment C) and DSRIP Funding & Mechanics Protocol (Attachment D) have been approved. These protocols are found to be in accordance with the Special Terms and Conditions (STC) of New Hampshire's section 1115 Medicaid demonstration, entitled "Building Capacity for Transformation" (Project No. 11-W-00301/1). These protocols are approved for the period starting with the date of this approval letter through December 31, 2020. Per STCs 26, 27 and 32, the approved DSRIP Protocols are hereby incorporated into the STCs as Attachments C and D, respectively.

Your Project Officer is Mr. Adam Goldman. He is available to answer any questions concerning your section 1115 demonstration. He can be reached via phone at 410-786-2242 or email at Adam.Goldman@cms.hhs.gov.

Official communications regarding program matters should be sent simultaneously to Mr. Goldman and to Mr. Richard McGreal, Associate Regional Administrator, in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Richard McGreal
Centers for Medicare & Medicaid Services
JFK Federal Building
Room 2325
Boston, MA 02203
Telephone: (617) 565-1226
E-mail: Richard.McGreal@cms.hhs.gov

We commend New Hampshire for its commitment to ensuring that the investment made herein is constructive and that meaningful transformation occurs within the demonstration period. We look forward to working closely with New Hampshire to monitor progress along the way.

Sincerely,

[redacted]

Eliot Fishman
Director

Enclosure(s)

cc: Richard McGreal, ARA, Boston Regional Office

ATTACHMENT C: DSRIP PLANNING PROTOCOL

New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration
Approved July 20, 2016

I. Preface

a. Delivery System Reform Incentive Payment Fund

On January 5, 2016, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's request for a section 1115(a) Medicaid demonstration (hereinafter "demonstration") entitled *Building Capacity for Transformation*, a Delivery System Reform Incentive Payment (DSRIP) program. Under the DSRIP demonstration, the state will make performance-based funding available to regionally-based Integrated Delivery Networks (IDNs) that serve Medicaid beneficiaries, with the goal of transforming New Hampshire's behavioral health delivery system by strengthening community-based mental health and substance use disorder services and combatting the opioid crisis. The demonstration is currently approved through December 31, 2020.

b. DSRIP Planning Protocol

The requirements specified in the STCs are supplemented by the Quarterly Report Format (Attachment A), the DSHP Claiming Protocol (Attachment B), the DSRIP Planning Protocol (Attachment C), and the DSRIP Program Funding and Mechanics Protocol (Attachment D).

In accordance with STC 26, the DSRIP Planning Protocol (this attachment, Attachment C) describes the context, goals and objectives of the demonstration in Section II; identifies a menu of delivery system improvement projects in Section III; specifies a set of project stages, milestones and metrics to be reported by IDNs in Section IV; details the requirements of the IDN Project Plans in Section V; and specifies a process to allow for potential IDN project plan modification in Section VI.

In accordance with STC 26, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

c. Supporting Project and Metrics Specification Guide

This attachment will be supplemented by a Project and Metrics Specification Guide developed by the state and approved by CMS. This Guide provides more technical detail on the projects described in Section III below, including the process milestones for each project. It will assist IDNs in developing and implementing their projects and will be used in the state's review of the IDN Project Plans, described in Section V below.

II. Context, Goals and Objectives

a. New Hampshire Context

New Hampshire's *Building Capacity for Transformation* Section 1115 demonstration aims to transform the way care is delivered to some of the most medically complex and costly Medicaid beneficiaries in the state as well as to children, youth and adults with undiagnosed or untreated behavioral health conditions. A number of factors make behavioral health transformation a priority of the state including the expansion of coverage through the New Hampshire Health Protection Program (NHHPP) to cover the new adult group, an estimated one in six of whom have extensive mental health or substance use disorder needs. In addition, New Hampshire now covers substance use disorder (SUD) services for the NHHPP population, and the state is targeting extension of the SUD benefit to the entire Medicaid population in state fiscal year 2017. Finally, the expansion of coverage for new populations and new services coincides with an epidemic of opioid addiction in the state and across New England.

The demand for mental health and substance use disorder services is increasing, and the existing capacity is not well-positioned to deliver the comprehensive and integrated care that can most effectively address the needs of patients with behavioral health conditions or comorbid physical and behavioral health diagnoses. This demonstration responds to this pressing need to transform New Hampshire's behavioral health delivery system and combat the opioid epidemic. It is a critical element of the state's comprehensive response, which also includes a number of other initiatives such as efforts to change prescribing patterns for opioid-based pain killers; a number of workforce development initiatives; the work of the Governor's Taskforce on Drug and Alcohol Abuse; implementation of the Mental Health Settlement Agreement; and participation in CMS's Innovation Accelerator Program (IAP) on mental and physical health integration (PMH). By design, the demonstration builds on and coordinates with these other initiatives, but does not replicate them.

Under the demonstration, diverse sets of health and social service providers within regions across the state will create IDNs capable of implementing evidence-supported programs that address the needs of Medicaid beneficiaries with behavioral health conditions. The principle elements of these programs will include:

- Integrating physical and behavioral health (mental health and SUD) to better address the full range of beneficiaries' needs;
- Expanding mental health and substance use disorder treatment capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions across care settings through improved coordination for individuals with behavioral health (mental health and SUD) conditions.

The population to be addressed by the demonstration includes Medicaid beneficiaries of all ages with, or at risk for, behavioral health conditions ranging from moderate depression and anxiety to substance use disorder, to serious mental illness. While some of these conditions respond well to prevention strategies, early intervention and a short term course of treatment, others are serious chronic illnesses that require a long term recovery process often resulting in ongoing treatment and management.

b. Demonstration Goals and Objectives

The demonstration is aimed at achieving the following goals:

- Improve the health and well-being of Medicaid beneficiaries and other New Hampshire residents with behavioral health conditions through the implementation of evidence-supported programs coupled with access to appropriate community-based social support services to improve physical and behavioral health outcomes.

- Improve access to behavioral health care throughout all of NH's regions by:
    - Increasing 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,
    - Enabling robust technology solutions to support care planning and management and information sharing among providers and community based social support service agencies, and
    - Incentivizing the provision of high-need services, such as medication-assisted treatment for substance use disorders, peer support and recovery services.

- Foster the creation of IDNs that are built upon collaboration among partners including Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), other mental health providers, SUD clinics (including recovery providers), hospitals, independent primary care providers (PCPs), psychiatrists, psychologists and other behaviorists, medical specialists, county organizations such as nursing facilities, peer and family support counselors, and community-based social support agencies that

serve the target population in a region or regions. As described in detail in the Program Funding and Mechanics Protocol (Attachment D), IDNs must ensure they have a network of both medical and non-medical providers that together represent the full spectrum of care and related social services (e.g., housing, food access, income support, transportation, employment services, and legal assistance) that might be needed by a child, youth or adult with a mental health or substance use disorder in their geographic region.

- Reduce the rate of growth in the total cost care for Medicaid beneficiaries with behavioral health conditions by reducing avoidable admissions and readmissions for psychiatric and physical diagnoses and avoidable use of the Emergency Department (ED) through more effective use of community-based options.

To achieve these goals the IDNs will be charged with selecting and implementing specific evidence-supported projects and participating in statewide planning efforts. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings. In addition the IDNs will engage in a phased transition to Alternative Payment Models (APMs). These four elements are embedded in the following demonstration objectives:

1. Increase 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, the cycling of justice-involved individuals between jail and the community due to untreated behavioral health conditions, and wait times for services.

2. Promote integration of physical and behavioral health providers in a manner that breaks down silos of care among primary care, SUD and mental health providers. The level of integration to be achieved will be based on existing standards being developed through the State Innovation Model (SIM) planning process and the SAMHSA-defined standards for *Levels of Integrated Healthcare*.

3. Enable coordinated care transitions for all members of the target population (i.e., Medicaid beneficiaries with or at risk for mental health or SUD conditions) regardless of care setting (e.g. CMHC, primary care, inpatient hospital, corrections facility, SUD clinic, crisis stabilization unit). The objective is to ensure that the intensity level and duration of transition services are fully aligned with an individual's documented care plan, which will be based on an up-to-date, comprehensive core standardized assessment.

4. To establish a sustainable approach to financing IDN activities through greater use of alternative payment strategies, moving the State from volume-based to primarily value-based payment over the course of the demonstration. Drawing on the IDNs and the projects they are implementing, the State will create a roadmap for using Alternative Payment Methodologies for at least 50 percent of Medicaid payments by the end of the demonstration.

To achieve these objectives, each IDN will be required to build a care continuum with the capacity to meet the needs of Medicaid beneficiaries with behavioral health conditions (diagnosed and at-risk) and to implement projects to further the objectives and goals of the demonstration. Additional details on the projects that IDNs are expected to implement and related metrics are provided in Sections III and IV. Please refer to Attachment D, Section II (c) for information on the types of providers required to be included in each IDN. The care continuum is defined to include outreach, intake, assessment, diagnosis, referral to treatment, treatment, care management and recovery/relapse prevention services.

As described in more detail in Attachment D, Section VII, New Hampshire is developing a systematic approach to overseeing the demonstration to support the IDNs and to ensure program integrity. These activities include allocation of dedicated state staff, regular monitoring and oversight of IDNs through reporting requirements and potential audits, and, accountability through the performance milestones and metrics outlined in Section IV.

III. Project Protocols Menu

a. Overview of Project Categories

Each IDN will be required to implement six projects to address the needs of Medicaid beneficiaries with diagnosed and undiagnosed behavioral health conditions within the population it serves. These six projects will be spread across the following three categories:

- Statewide Projects (2 mandatory projects for all IDNs)
- Core Competency Project (1 mandatory project for all IDNs); and
- Community Driven Projects (IDNs select 3 projects among options)

Three of these projects are foundational to the transformation initiative, and, therefore, are mandatory for all IDNs. These projects are the cornerstone of the demonstration. 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. For each project, the IDN will develop detailed plans as part of the IDN's Project Plan. As described in Section IV, project performance will be measured based on state-defined milestones and metrics

that track: project planning/implementation progress; clinical quality and utilization indicators; and progress towards transition to Alternative Payment Models.

b. Description of Project Categories

1. **Statewide Projects (Mandatory for all IDNs)**

   Each IDN will be required to implement two Statewide Projects that are designed to address the following critical elements of New Hampshire's vision for transformation: (1) a workforce that is equipped to provide high-quality, integrated care throughout the state and, (2) an HIT infrastructure that allows for the exchange of information among providers and supports a robust care management approach for beneficiaries with behavioral health conditions.

IDNs will be required to implement the following two Statewide Projects:

- **A1. Behavioral Health Work Force Capacity Development**
- **A2. Health Information Technology (HIT) Infrastructure to Support Integration**

The effectiveness of these projects is dependent on active coordination across IDNs, and as such they will begin with a state-wide planning effort that includes representatives from across New Hampshire. In short order, however, the projects will require each IDN to take action to expand capacity for behavioral health services and improve the IT infrastructure needed to support effective care for Medicaid beneficiaries affected by behavioral health concerns. All IDNs will be required to participate in each of these projects through their respective collaborative statewide work groups with members drawn from across the mental health and substance use disorder provider communities in each IDN, as well as other subject matter experts and stakeholders.

The decision to begin both of these projects with a statewide planning process reflects 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 demonstration goals and with assessments of the current workforce and HIT gaps across the state and IDN regions. This analysis 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.

Additional detail on each of the Statewide Projects:

A1. Behavioral Health Work Force Capacity Development.
This project aims to establish the workforce required to meet the objectives of the demonstration. Through a statewide planning process, the project will support increased community-based behavioral health service capacity through the education, recruitment and training of a 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 gaps using a framework established by a Statewide Behavioral Health Workforce Capacity Taskforce.

The Taskforce will be facilitated by the State or its delegate and be made up of the following representatives from IDNs and other stakeholders across the state:

- One (1) mental health-focused representative from each IDN
- One (1) SUD-focused representative from each IDN
- 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

Through a process facilitated by the State or its delegate, the Taskforce will spearhead the following activities:

- An assessment of the current workforce gaps across the state and IDN regions, informed by an inventory of existing workforce data/initiatives and data gap analysis

- Identification of the workforce capacity needed to meet the demonstration goals and development of a state vision and strategic plan to efficiently implement workforce solutions, for approval by the state

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

A2. Health Information Technology (HIT) Infrastructure to Support Integration

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

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

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

Each IDN will then develop and implement IDN-specific implementation plans and timelines based on the Taskforce's assessment and recommendations, the IDN's current HIT capacity, and the IDN-specific community needs assessment. While not every HIT infrastructure gap can be addressed through this demonstration, examples of where the HIT project can drive improvements include:

1) Level of IDN participants utilizing ONC Certified Technologies[1]

[1] http://oncchpl.force.com/ehrcert

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 and quality data for operational and programmatic evaluation purposes.
10) 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. **Core Competency Project (Mandatory for all IDNs)**

Each IDN will be required to implement one Core Competency Project to ensure that behavioral health conditions are routinely and systematically addressed in the primary care setting and vice versa. Foundational to transformation efforts, IDNs are required to integrate mental health and substance use disorder services and primary care through the following Core Competency project:

- **B1. Integrated Healthcare**

Primary care providers, behavioral health providers, and social services organizations will partner to implement an integrated care model that reflects the highest possible levels of collaboration/integration as defined within the SAMHSA Levels of Integrated Healthcare. The

model will enable providers to collaborate to prevent and quickly detect, diagnose, treat and manage behavioral and medical conditions using standards of care that include:

- Comprehensive core standardized assessment framework that includes evidence based universal screening for depression and SBIRT (for SUD)
- Multi-disciplinary care teams that provide care management, care coordination and care transition support
- Documented care plans that integrate physical and behavioral health needs of the target population
- Protocols and systems that enable timely transmission of critical patient information among care team members

IDNs must participate in this project and fulfill state-specified requirements in order to be eligible for DSRIP incentive payments.

3. **Community Driven Projects (IDNs can select among options)**

Each IDN is required to select a total of three community-driven projects from a Project Menu established by the state. The IDN Project Menu is broken down into three categories, and IDNs will select one project within 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. IDNs will be required to conduct a behavioral needs assessment as part of development of the IDN Project Plans described further in Section V. The menu of community-driven projects gives IDNs the 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 variety of approaches to change the way care is delivered. The goal is to employ these services across the state to ensure a full spectrum of care is accessible for individuals with active diagnoses and those who are undiagnosed or at risk.

Given New Hampshire's opioid addiction crisis, one of the driving purposes for the demonstration is to provide New Hampshire with additional resources to combat this epidemic and other substance use disorders. Through the mandatory statewide Behavioral Health Work Force Capacity Development Project, IDNs will address SUD workforce capacity, currently a major barrier to providing an effective response to the opioid epidemic. In addition, the required

Core Competency project includes a focus on screening, SBIRT and use of Medication Assisted Treatment to ensure that every IDN is using these tools to identify and address opioid addiction, as well as other mental health and substance use disorders. Finally, each IDN must ensure that at least one of the three projects it selects from the Community Driven Project menu has the SUD population as its primary focus. (D1, D3, E3, or E4, noted with an asterisk below).

1. **Care Transitions Projects:** Support beneficiaries with transitions from institutional setting to community
    - **C1: Care Transition Teams**
    - **C2: Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues**
    - **C3: Supportive Housing**

2. **Capacity Building Projects:** Expand availability and accessibility of evidence supported programs across the state and supplement existing workforce with additional staff and training
    - **D1: Medication Assisted Treatment (MAT) of Substance Use Disorders***
    - **D2: Expansion of Peer Support Access, Capacity, and Utilization**
    - **D3: Expansion in intensive SUD Treatment Options, including partial-hospital and residential care***
    - **D4: Multidisciplinary Nursing Home Behavioral Health Service Team**

3. **Integration Projects***:* Promote collaboration between primary care and behavioral health care
    - **E1: Wellness programs to address chronic disease risk factors for SMI/SED populations**
    - **E2: School-based Screening and Intervention**
    - **E3: Substance Use Treatment and Recovery Program for Adolescents and Young Adults***
    - **E4: Integrated Treatment for Co-Occurring Disorders***
    - **E5: Enhanced Care Coordination for High-Need Populations**

* Denotes projects with SUD population as a primary focus. IDNs are required to select at least one of these projects.

Table 1. Project Protocols Menu

#	PROJECT	DESCRIPTION
A. STATE-WIDE PROJECTS		*IDNs required to implement both projects*
A1	**Behavioral Health Workforce Capacity Development**	This project aims to build and maintain the workforce required to meet the objectives of the DSRIP demonstration. It will increase community-based behavioral health service capacity through the education, recruitment and training of a 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 gaps using a framework established by a Statewide Behavioral Health Workforce Capacity Taskforce.
A2	**Health Information Technology (HIT) Infrastructure to Support Integration**	The objective of this project is to develop the HIT infrastructure required to support high-quality, integrated care throughout the state. Initially, the project will establish a statewide Taskforce with members 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). The Taskforce will assess the current HIT infrastructure gaps across the state; develop a consensus on HIT priorities related to the demonstration; and identify the infrastructure required to meet demonstration goals. Each IDN will then develop and implement an IDN-specific plan to close its HIT gap.
B. CORE COMPETENCY PROJECT		*IDNs required to implement this project*
B1	**Integrated Healthcare**	The integration of care across primary care, behavioral health (mental health and SUD) and social support service providers is a foundational core competency requirement for participants in the demonstration. This project will assist primary care and behavioral health providers in reaching the highest feasible level of integrated care based on the approach described in SAMHSA's Standard Framework for Levels of Integrated Healthcare. Its components include: • Use of a Comprehensive Core Standardized Assessment framework that includes evidence based universal screening for depression and SBIRT. The assessment process will be the basis for an individualized care plan used by the care team to guide the treatment and management of the target 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). • Development of a 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), and 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. • Enhanced information sharing including shared care plans and documented work flow that ensures timely communication of a

#	PROJECT	DESCRIPTION
		defined set of clinical and other information critical to diagnosis, treatment and management of care.
C. COMMUNITY-DRIVEN PROJECTS		*IDNs to select one project from the Care Transitions, Capacity Building, and Integration Categories.* **NOTE: At least one of the three projects an IDN selects from the Community Driven Project menu must have the SUD population as its primary focus (D1, D3, E3, or E4, noted with an asterisk)**
C. Care Transitions		*IDNs to select one project from this category*
C1	**Care Transition Teams**	This project will follow the evidence-based "Critical Time Intervention" (CTI) approach to providing care at staged levels of intensity to patients with serious mental illness during transitions from the hospital setting to the community. It is designed to prevent readmissions to acute care, inappropriate use of the ED, and recurring homelessness. Under CTI, a multi-disciplinary team follows a three-phase approach to assisting individuals with transitions out of the hospital, including veterans, people with a history of homeless, and formerly incarcerated individuals.
C2	**Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues**	The community re-entry project assists adults with mental health conditions and/or substance use disorders who are leaving correctional facilities in maintaining their health and recovery in the community. The program, which is initiated pre-discharge and continues for 12 months post discharge, provides them with integrated primary and behavioral health services, care coordination and social and family supports. By promoting the stability and recovery of participants, it is designed to prevent unnecessary hospitalizations and ED usage among these individuals.
C3	**Supportive Housing**	This project will provide individuals at risk of "ping ponging" between institutions and the community with a combination of affordable housing and supportive services. IDNs will partner with community housing providers to develop transitional and permanent supportive housing for individuals with severe mental illness, a history of homelessness, and/or major substance use disorders. By improving the physical health, behavioral health, and self-sufficiency of participating individuals, the project is expected to reduce avoidable readmissions, ED visits, and incarceration due to mental health conditions or substance use disorders.
D. Capacity Building		*IDNs to select one project from this category*
D1*	**Medication Assisted Treatment (MAT) of Substance Use Disorders***	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, and mental health treatment programs. The project's goal is to successfully treat more individuals with substance use disorders and to help prevent relapse and sustain recovery.

#	PROJECT	DESCRIPTION
D2	**Expansion of Peer Support Access, Capacity, and Utilization**	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 an 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.
D3*	**Expansion in intensive SUD Treatment Options, including partial-hospital and residential care ***	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.
D4	**Multidisciplinary Nursing Home Behavioral Health Service Team**	Nursing homes typically have staff with extensive expertise on the physical needs of residents and dementia, but they often lack the specialized geriatric-psychiatric expertise required to treat residents with significant mental illness. As a result, nursing homes sometimes admit residents experiencing psychiatric problems to inpatient care, including to New Hampshire Hospital. This project will provide nursing homes with multi-disciplinary care teams to treat and manage nursing home residents with significant mental illness. It is expected to reduce ED and hospital visits and/or length of stays in the hospital by nursing home residents.
E. Integration		*IDNs to select one project from this category*
E1	**Wellness programs to address chronic disease risk factors for SMI/SED populations**	Individuals with severe mental illness (SMI) or serious emotional disturbances (SED) commonly experience obesity, tobacco addition, 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.
E2	**School-based Screening and Intervention**	This project will build the knowledge and skills of school-based staff so that they can better recognize children in need of mental health or substance use services and link them with appropriate care. The services will be provided through 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 children and youth, the project is anticipated to result in improved diagnosis of and early intervention/treatment for their mental health and substance use disorder conditions.

#	PROJECT	DESCRIPTION
E3*	**Substance Use Treatment and Recovery Program for Adolescents and Young Adults***	The goal of this project is to prevent substance misuse and risky behaviors among adolescents and young adults that can lead to 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 in a variety of settings that have been shown effective at promoting abstinence, full recovery and restoration to a healthy lifestyle in adolescents and young adults. The interventions include stabilization and detoxification programs for youth in crisis; family-based approaches (e.g. ARISE model; multi-dimensional family therapy, and adolescent community reinforcement approach); adolescent-specific 12-step programs; and a range of other interventions aimed at expanding capacity and screening and assessment for adolescents and young adults.
E4*	**Integrated Treatment for Co-Occurring Disorders***	This project is specifically targeted at individuals with co-occurring SUD and severe mental illness diagnoses and involves the implementation of an evidence-based multi-disciplinary program combining substance use disorder treatment and mental health treatment for people with severe mental illness using 'stages of change/treatment' approach along with pharmacological and psychosocial therapies and holistic program supports. Research on the integrated dual disorder treatment model 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. For more information: http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367
E5	**Enhanced Care Coordination for High-Need Populations**	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.

* Denotes projects with SUD population as a primary focus. IDNs are required to select at least one of these projects.

IV. Project Stages, Milestones, and Metrics

a. Overview

In accordance with STC 27g, the state will shift accountability over the duration of the demonstration, from a focus on rewarding achievement of process (Stage 1) milestones in the early years of the demonstration or rewarding improvement on performance metrics (Stage 2, 3, and 4) in the later years of the demonstration. During Years 2 and 3, IDNs will be required to report progress against several process milestones for each project, as described further below and as detailed in the Project and Metrics Specification guide. These process milestones are, by

definition, 'pay-for-reporting' or 'P4R,' since IDNs will be rewarded based on reported progress, subject to audit.

IDNs will also be accountable for achieving targeted levels of improvement along several *outcome* measures. These measures are primarily 'pay-for-performance,' or 'P4P,' since IDNs are only rewarded if specific outcome metric targets are achieved. However, in Years 2 and 3, a subset of these measures will be rewarded on a P4R basis to allow IDNs time to establish the necessary reporting infrastructure.

The table below summarizes the different categories of measures, which are described further below. Please refer to Appendix A for a detailed list of the outcome measures (Stage 2 and 3).

Table 3. Demonstration Milestone/Metric Categories

Milestone/Metric Type	Year 2 (2017)	Year 3 (2018)	Year 4 (2019)	Year 5 (2020)
Process Milestones (Stage 1 Project Planning and Progress Milestones)	P4R	P4R	N/A	N/A
Outcome Metrics (Stage 2 Project Utilization Milestones, Stage 3 System Transformation Milestones)	P4R	P4R/P4P	P4P	P4P
Alternative Payment Model Milestones (Stage 4)	P4R	P4R	P4R	P4R

b. Process Milestones (Stage 1 Capacity Building Elements Description, Progress Milestones, and Metrics)

During DSRIP Year 1, IDNs will be accountable for the development, submission, and approval of an IDN Project Plan. As part of this Project Plan, each IDN will provide a timeline for implementation and completion of each project, in alignment with state specified process milestones. These milestones will reflect demonstrated progress against meeting project objectives during Years 2 and 3. Detailed parameters and guidance related to these milestones are reflected in the Project and Metrics Specification Guide. General categories of Stage 1 progress milestones required to be accomplished by IDNs for each project include:

- Development of a detailed implementation plan, including timing of activities, workforce plan, and budget;
- Design and development of a clinical services infrastructure, which may include identification or development of standardized assessment tool(s), protocols, documented roles and responsibilities for team members, a training plan, training curricula, agreements with collaborating organizations, and an evaluation plan, including metrics that will be used to measure program impact;

- Ongoing reporting of standardized process measures, including number of individuals served, number of staff recruited and trained, and impact measures as defined in the evaluation plan.

c. <u>Outcome Metrics</u> (Stages 2 and 3: Project Utilization Milestones and System Transformation Utilization Milestones)

Please see Appendix A for the project utilization and system transformation metrics that will be used to measure IDN progress against meeting project goals and targeted levels of improvement against outcome-based performance indicators. Section IV(c) of Attachment D goes into further detail on how these measures will be used to evaluate IDN performance.

d. Stage 4 Alternative Payment Model Milestones

Pursuant to STCs 33, the state will develop a multi-year roadmap for how it will "amend contract terms and reflect new provider capacities and efficiencies generated by the demonstration." By April 1, 2017, the state will submit to CMS the plan, which will address how the state will implement a goal of using APMs for at least 50 percent of Medicaid provider payments. In developing this roadmap, the state will engage with Manage Care Organizations, IDNs, providers and other stakeholders to evaluate payment model options, set payment methodology standards, and establish intermediate milestones. Throughout this process, the tate will draw on the Alternative Payment Models framework proposed by CMMI's Health Care Payment Learning and Action Network, as well as the APM typologies established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the associated proposed rules. The process and models also will be informed by New Hampshire's experience with DSRIP implementation, participation in the CMS Innovation Accelerator Program (IAP) Physical and Mental Health Integration PMH initiative, and other New Hampshire-specific considerations. Of necessity, the plan will be flexible, but, currently, it is anticipated hat allowable APM models may include bundled payments (with up and downside risk), PCMH primary care payments with shared savings, population based payments for condition-specific care (e.g., via an ACO or PCMH), and comprehensive population-based payment models.

As required by STC 24, Stage 4 measures will be used to evaluate the participation of IDNs in the development of the roadmap and preparations for accepting APMs. They will be required to participate in the State's roadmap development process. This will entail assessing the current use of APMs among IDN participants; identifying current capacity for engaging in APM arrangements; and participating in workgroups and stakeholder meetings used to inform the development of the roadmap. In addition, IDNs will be expected to develop an IDN-specific plan for implementing the roadmap, which will contain IDN-specific outcome measures. Since these measures will be a function of the state roadmap and IDN-specific plans, it is not possible

to specify them at this time, but, it is expected that they will assess IDN progress in developing the financial, clinical and legal infrastructure required to support APMs, as well as in building relationships with MCOs.

Table 4. APM Milestones Menu

Alternative Payment Model (APM) Milestones
Conduct IDN baseline assessment of current use of and capacity to use APMs among partners
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings
Develop an IDN-specific roadmap for using APMs,
Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal and clinical preparedness and engagement with MCOs

V. Requirements for IDN Project Plans

Once IDNs have been selected though the process described in the Program Funding and Mechanics Protocol (Attachment D), IDNs will prepare and submit Project Plans. Generally, the Project Plan will provide a blueprint of the work that an IDN intends to undertake, explain how its work responds to community-specific needs and furthers the objectives of the demonstration, and provide details on its composition and governance structure. In order to be eligible to receive IDN incentive payments, an IDN must have an approved IDN Project Plan.

The state will develop and post a draft IDN Project Plan Template for public comment by 7/1/16, and issue a final version by 8/1/16. IDNs may use their capacity building and project design funds to prepare their Project Plans. As they develop their Project Plans, they must solicit and incorporate community input to ensure they reflect the specific needs of the regions they are serving. After the Project Plans are submitted to the state, they will be reviewed by an independent assessor contracted by the state, as described in the Attachment D, and shall be subject to additional review by CMS.

Each IDN Project Plan must include the following:

1. *IDN Behavioral Health (Mental Health and Substance Use Disorder) Community Needs Assessment:* Each IDN must present a needs assessment that includes:
    - A demographic profile of the Medicaid and general population living in the IDN Service Region, including by race, ethnicity, age, income, and education level
    - Prevalence rates of MH/SU disorders among both the general and the Medicaid population including rates of serious mental illness, substance use (alcohol, tobacco, opioids, co-occurring disorders), and, to the extent possible, undiagnosed conditions.

- An assessment of the gaps in care for the target population and sub populations, (e.g., age groups, opiate users, those with co-occurring (MH/SU) disorders including the developmentally disabled)
- Identification of the current community mental health and substance use resources available for beneficiaries living in an IDN's region across the care continuum, including during recovery
- Identification of current community-based social services organizations and resources that could provide social supports to beneficiaries with behavioral health conditions, including housing, homeless services, legal services, financial help, education, nutritional assistance, and job training or other employment services

2. *IDN Community Engagement:* In developing its Project Plan, the IDN must demonstrate that it has solicited and incorporated input from individual members of the target population, the broader community and organizations that serve the community, particularly those who serve the Medicaid population and those individuals and populations with mental health and substance use disorders. The Plan must also describe the process the IDN will follow to engage the public and how such engagement will continue throughout the demonstration period.

3. *IDN Composition:* The IDN Project Plan will describe the membership composition of the network. IDNs must include a range of organizations that can participate in required and optional projects. Together, these partners must represent the full spectrum of care and related social services that might be needed by an individual with a mental health or substance use condition. Partners will include CMHCs, other mental health providers, primary care providers, substance use providers including recovery services, peer supports, hospitals, home care providers, nursing homes and community based social support service providers. Please refer to the Program - Funding and Mechanics Protocol (Attachment D) for additional detail on specific IDN composition requirements.

4. *IDN Governance:* The IDN Project Plan will describe how the IDN shall ensure that the governance processes established in the organizational structure of the IDN provide for full participation of IDN partners in decision-making processes and that the IDN partners, including the administrative lead, are accountable to each other, with clearly defined mechanisms to facilitate decision-making. Each IDN must have an organizational structure that enables accountability for the following domains: financial governance and funds allocation, clinical governance, data/information technology, community engagement and workforce capacity. Please see the Program

Funding and Mechanics Protocol (Attachment D) for additional state parameters on IDN governance.

5. *Financial governance and funds allocation:* The IDN Project Plan must describe how decisions about the distribution of funds will be made, the roles and responsibilities of each partner in funds distribution, and how the IDN will develop an annual fund allocation plan. The plan should also include a proposed budget that includes allocations for central services support, IT, clinical projects, and workforce capacity.

6. *Clinical governance:* The IDN Project Plan must describe how and by whom standard clinical pathways will be developed and a description of strategies for monitoring and managing patient outcomes.

7. *Data/Information Technology:* The IDN Project Plan must provide a data governance plan and a plan to provide needed technology and data sharing capacity among partners and reporting and monitoring processes in alignment with state guidance.

8. *Workforce capacity:* The IDN Project Plan must develop a plan aligned with the Statewide Workforce project goals to increase the numbers and types of providers needed to provide rapid access and integrated treatment in mental health and substance use programs, support services and primary care.

9. *IDN Project Selection:* The IDN Project Plan must describe its rationale for selecting from among the community driven projects. The plan must describe how these projects align with the demonstration objectives and how they will transform care delivery within the IDN. IDNs should select projects principally based on the findings from the MHSU Needs Assessment and should consider opportunities for rapid deployment among other factors.

10. *Implementation Timeline and Project Milestones:* The IDN Project Plan must provide a timeline for implementation and completion of each project, in alignment with state specified process milestones included in the Project Metrics and Specification Guide.

11. *Project Outcomes:* In accordance with STC 28e, the IDN Project Plan must describe outcomes it expects to achieve in each of the four project stages, in alignment with metrics and parameters provided by the state.

12. *IDN Assets and Barriers to Goal Achievement*: Each IDN Project Plan must describe the assets that the IDN brings to its delivery transformation program, and the challenges or barriers the IDN expects to confront in improving outcomes and

lowering costs of care for the target population. The Plan must also address how the IDN will mitigate the impact of these challenges and what new capabilities will be required to be successful.

VI. Process for IDN Project Plan Modification

No more than once a year, IDNs may submit proposed modifications to an approved IDN Project Plan for state and CMS review and approval/denial. In certain extremely limited cases it may become evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments outside of the IDN's control require the IDN to modify its original plan. Examples of these circumstances could include a significant regulatory change that requires an IDN to halt a planned project intervention (e.g. a specific opioid antagonist) or substantial changes to the way a standard performance metric is measured, requiring an IDN to modify its planned approach.

In order to request a Project Plan modification, an IDN must petition the state by submitting a formal request with supporting documentation for review by the state in consultation with CMS. The state will have 60 days to review and respond to the request. Project Plan modifications may not decrease the scope of a project unless they also propose to decrease the project group's valuation, nor can they lower expectations for performance because it has proven more difficult than expected to meet a milestone.

VII. Appendix A. Project Outcome Metrics (Stages 2 and 3)

Table 1: Project Outcome Metrics (Stages 2 and 3)

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	Periodicity	Statewide measure?[2]	Active Year(s)[3]				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 PCR 2017	IDN; Claims/ Encounters and Non-Claim Discharges from NHH for age 21-64	Per HEDIS	Adult (18+) BH/SUD Population as of end of data reporting period	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 FUA	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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 FUM	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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 FUH 2017 (w/Addition of IMD discharges)	DHHS; Claims/ Encounters/ NHH Discharge Data	Based on HEDIS FUH (w/addition of any IMD discharges)	Based on HEDIS FUH (w/addition of any IMD discharges)	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 FUH 2017 (w/Addition of IMD discharges)	DHHS; Claims/ Encounters/ NHH Discharge Data	Based on HEDIS FUH (w/addition of any IMD discharges)	Based on HEDIS FUH (w/addition of any IMD discharges)	Annual		-	P4P	P4P	P4P	B1, C1, C2, C3, D4, E4, E5

[2] 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.

[3] "P4R = Pay for Reporting"; "P4P = Pay for Performance"

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	Periodicity	Statewide measure?[2]	Active Year(s)[3]				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	Population screened and if positive follow up plan documented in EHR	Population Age 12+ as of end of data reporting period	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 2017	IDN; IDN EHR Output	Per CMS	Per CMS	Semi-Annually		-	P4R	P4P	P4P	All
Patient Reported Experience of Care	**Global Score for Mini-CAHPS Satisfaction Survey at IDN Level for kids and adults[4]**	Subset of Health Plan CAHPS 5.0 questions	DHHS; DHHS Mini-CAHPS Survey	Average responses using NCQA adapted ranking methods	Weighted survey respondents (parents and adults combined)	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	Number with appropriate assessment documented in EHR	Population Age 12+ as of end of data reporting period	Semi-Annual	X	-	P4R	P4P	P4P	B1, C1,C2, D1, E3, E4, E5

[4] This measure will reflect Composite Customer Satisfaction following NCQA Plan Ranking methodology, which combines the Ease of Getting Care and Satisfaction with Physicians question sets (excluding health plan customer service questions). IDN targets will be established based on the weighted points required to achieve a ranking of 4 out of 5 on NCQA scale for Medicaid plans. IDNs that exceed this goal, would be expected to increase by point levels by 5% per year thereafter until they reach the points needed to achieve a ranking of 5. IDNs that achieve a ranking of 5 would need to maintain these points to continue to receive incentive payments.

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	Periodicity	Statewide measure?[2]	Active Year(s)[3]				Associated Projects
								2017	2018	2019	2020	
Physical Health/Primary Care Clinical Quality/Screening and Assessment	**Global score for selected general HEDIS physical health measures, adapted for BH population**	HEDIS (adapted) 2017 CBP, SPC, CDC, SPD, PCE, MMA	IDN/DHHS; Claims/ Encounters/IDN EHR Report	Average responses using NCQA adapted ranking methods	Adult (18+) BH/SUD Population as of end of data reporting period	Annual		-	P4R	P4P	P4P	B1, C1, C2, D1, D2, D4, E1, E3, E4
BH Care Clinical	**Global score for selected BH-focused HEDIS measures**	HEDIS 2017 AMM, ADD, SSD, SMD, SMC, SAA, APM	IDN/DHHS; Claims/ Encounters/IDN EHR Report	Average responses using NCQA adapted ranking methods	Per HEDIS	Annual			P4P	P4P	P4P	B1, C1, C2, D1, D2, D4, E1, E3, E4
Physical Health/Primary Care Clinical Quality/Screening and Assessment	**Percent of BH Population With All Recommended USPSTF A&B Services (See Table 2 Supplemental Specifications)**	See Table 2 Supplemental Specifications	IDN; Claims/ Encounters/IDN EHR Report	Number with appropriate service documented in EHR	BH/SUD population as of end of data reporting period	Annual		-	P4P	P4P	P4P	B1, D4
Physical Health/Primary Care Clinical Quality/Screening and Assessment	**Recommended Adolescent (age 12-21) Well Care visits**	HEDIS Hybrid 2017 AWC	DHHS; Claims/ Encounters & IDN EHR Report	Per HEDIS	Per HEDIS	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**	NQF 0027 PQRI 115 2017	IDN; IDN EHR Report	Per PQRI	Per PQRI	Semi-Annual		-	P4R	P4P	P4P	All
Population Level Utilization	**Frequent (4+ per year) ER Visits Users for BH Population**	DHHS Measure	DHHS; Claims/ Encounters	Number with 4 or more outpatient ED visits in the prior year	BH/SUD population as of end of data reporting period	Semi-Annual		-	P4P	P4P	P4P	All
Population Level Utilization	**Potentially Preventable ER Visits for BH Population and Total Population**	Adapted from DHHS MCO reporting AMBCARE Measure	DHHS; Claims/ Encounters	Per DHHS specification for MCO reporting	50/50 weighted average of BH/SUD population and rest of population as of end of data reporting period	Semi-Annual	X	-	P4P	P4P	P4P	All

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	Periodicity	Statewide measure?[2]	Active Year(s)[3]				Associated Projects
								2017	2018	2019	2020	
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**	2017 PQA	DHHS; Claims/ Encounters	Population screened and if positive follow up plan documented in EHR	Population Age 12+ as of end of data reporting period	Semi-Annual		-	P4P	P4P	P4P	B1, C1, C2, C3, D1, D2, D3, E3, E4, E5
Workforce Capacity	**Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)**	HEDIS IET 2017	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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 IET 2017	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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	Number who actually had visit within 7 days of referral	Population new to CMHC system per Phoenix data who had intake appointment	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; DHHS CMHC Phoenix Encounter Data Reporting System	Number who had first treatment visit within 7 days of intake appointment	Population new to CMHC system per Phoenix data who had intake appointment and were determined eligible for CMHC services	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; DHHS CMHC Phoenix Encounter Data Reporting System	Number who had first psychiatrist visit within 30 days of intake appointment	Population new to CMHC system per Phoenix data who had intake appointment and were determined eligible for CMHC services	Semi-Annual		-	-	P4P	P4P	B1, C1, C2, C3, E5

Table 2: Supplemental Specifications for "Percent of BH Population With All Recommended USPSTF A&B Services" Composite Measure (see Table 1)

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
Substance Use Disorder	Screening		Alcohol		Men, Women	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Substance Use Disorder	Early Treatment	Counseling	Tobacco		Men, Women	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Substance Use Disorder	Early Treatment	Counseling	Tobacco		Pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Substance Use Disorder	Early Treatment	Counseling	Tobacco		Adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Mental Health	Screening		Depression		Adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Mental Health	Screening		Depression		Men, Women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Mental Health	Screening		Intimate Partner Violence		Women	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Physical Health	Screening		CV	Blood Pressure		The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
Physical Health	Screening		CV	Cholesterol	Men	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
Physical Health	Screening		CV	Cholesterol	Men	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		CV	Cholesterol	Women	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		CV	Cholesterol	Women	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		CV	Obesity	Men, women	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Physical Health	Screening		Cancer	Breast Cancer	Women	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Physical Health	Screening		Cancer	Cervical	Women	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Physical Health	Screening		Cancer	Colon	Men, women	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		Cancer	Lung	Men, women	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Physical Health	Screening		Diabetes	Obesity	Men, women	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Physical Health	Screening		STD	Gonorrhea	Women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Physical Health	Screening		STD	Hep B	Men, women, adolescents	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
Physical Health	Screening		STD	Hep B	Pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Physical Health	Screening		STD	HIV	Men, women, adolescents	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
Physical Health	Screening		STD	HIV	Pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Physical Health	Screening		STD	Hep C	Men, women	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
Physical Health	Screening		STD	Syphilis	Men, women	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Physical Health	Screening		STD	Syphilis	Women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
Physical Health	Early Treatment			Aspirin use	Men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Physical Health	Early Treatment		CV	Aspirin use	Women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Physical Health	Early Treatment	Counseling	Obesity		Men, women	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
Physical Health	Early Treatment	Counseling	Obesity		Children, adolescents	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Physical Health	Early Treatment	Counseling	STD		Men, women, adolescents	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.

New Hampshire Building Capacity for Transformation Medicaid Demonstration

DRAFT PROJECT AND METRICS SPECIFICATION GUIDE

Contents

Introduction to Project and Metrics Specification Guide

Overview of Transformation 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 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 demonstration 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 demonstration, 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 demonstration).

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 though 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 demonstration, 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 coordinating 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, some practices 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	This project will establish the workforce required to meet the objectives of the DSRIP demonstration. It will increase community-based behavioral health service capacity through the education, recruitment and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of substance use disorder and mental health services. Under this project, each IDN will develop and implement a strategy for addressing its workforce issues using a framework established by a **Statewide Behavioral Health Workforce Capacity Taskforce**. This Taskforce will be formed with representation from IDNs and other stakeholders across the state. Through a process facilitated by the State or its delegate, the Taskforce will spearhead the following activities: • An assessment of the current workforce gaps across the state and IDN regions, informed by an inventory of existing workforce data/initiatives and data gap analysis • Identification of the workforce capacity needed to meet the demonstration goals and development of a state vision and strategic plan to efficiently implement workforce solutions, for approval by the state Based on this statewide planning effort, its own community needs assessments, and the community-driven projects it has selected, each IDN will then develop and implement its own workforce capacity plan. The plan must be approved by the state and executed over the course of the demonstration.
Target Population	All Medicaid beneficiaries
Target Participating Organizations	All participating IDN organizations
Related Projects	Project A1 is a foundational project that will establish the workforce needed by each IDN to meet the objectives of the DSRIP demonstration. As such, this project is closely tied with every other project being implemented by each IDN, and the plans implemented by IDNs as part of this project should reflect the workforce needs across all projects.
Project Core Components	**Phase 1: Form Statewide Behavioral Health Workforce Capacity Taskforce** *(August-September 2016)*

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

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, measureable 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 retain the workforce required to meet the DSRIP objectives of more capacity to serve New Hampshire residents with mental health and substance use disorders, including opioid addiction; better integration of physical and behavioral health care; and smoother transitions across care settings.
Process Milestones	In order to be eligible for performance funding associated with this statewide workforce project, IDNs must participate in planning at the statewide level and also design and implement workforce development plans at the IDN level. **Key milestones include:** 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
Additional Information related to inventory of existing workforce data, initiatives, and activities	Completed or in-process activities may include, but are not limited to: • 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 Agencies/Efforts the Taskforce and IDNs may consider coordinating with include: • 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

Project Pathway	Statewide Projects
Project ID	**A2**
Project Title	**A2: Health Information Technology (HIT)[1] Infrastructure to Support Integration**
Project Objective	**See also requirements for Project B-1** The objective of this project is to develop the HIT infrastructure required to support high-quality, integrated care throughout the state. Each IDN will be required to develop and implement a plan for acquiring the HIT capacity it needs to meet the larger demonstration objectives. To promote efficiency and coordination across the state, this project will be supported by a statewide planning effort that includes representatives from across New Hampshire, a statewide **Taskforce**. All IDNs will be required to participate in this Taskforce, with members drawn from across the mental health and substance use disorder provider communities in each IDN, as well as other members who can bring relevant experience and knowledge such as the NH Health Information Organization (NHHIO). Facilitated by DHHS representatives and/or delegates, this Taskforce will be charged with: a) Assessing the current HIT infrastructure gaps across the state and IDN regions b) Coming to consensus on statewide HIT implementation priorities given demonstration objectives c) Identifying the statewide and local IDN HIT infrastructure requirements to meet demonstration goals, including: i. Minimum standards required of every IDN ii. 'Desired' standards that are strongly encouraged but not required to be adopted by every IDN. Interoperability requirements will reference the ONC's 2016 Interoperability Standards Advisory where viable. iii. A menu of optional requirements. Each IDN will then develop and implement IDN-specific implementation plans and timelines based on the Taskforce's assessment and recommendations, the IDN's current HIT capacity, and the IDN-specific community needs assessment. The four DSRIP demonstration objectives driving the HIT infrastructure work are comprehensive and include: 1) Increasing the State's capacity to implement effective community based behavioral health prevention, treatment and recovery models that will reduce unnecessary use of inpatient and ED services, hospital readmissions, and wait times for services.

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

2) Promoting the integration of physical and behavioral health providers in a manner that breaks down silos of care among primary care, SUD and mental health providers.
3) Enabling coordinated care transitions for all members of the target population regardless of care setting (e.g. CMHC, community mental health providers, primary care, inpatient hospital, corrections facility, SUD clinic and crisis stabilization unit).
4) Supporting IDNs in participating in Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

Using the Taskforce's findings, its community needs assessment, and the community-driven projects it has selected, each IDN will be required to develop a strategy for closing key HIT infrastructure gaps among medical providers, behavioral health providers, and community-based service organizations, and to demonstrate the use of interoperability best practices such as those found in the Office of the National Coordinator for Health IT's (ONC) 2016 Interoperability Standards Advisory.[2] 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 Technologies[3]
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

[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.

	clinical quality data for operational and programmatic evaluation purposes. Ability for IDN participants to directly engage with their patients for items including but not limited to bi-directional secure messaging, appointment scheduling, viewing care records, prescription management, and referral management.
Target Population	All Medicaid beneficiaries
Target Participating Organizations	All participating IDN organizations
Related Projects	Project A2 is a foundational project to support statewide and IDN-level planning efforts associated with addressing select HIT gaps. As such, this project is closely tied with any project being implemented with HIT needs.
Project Core Components	***Phase 1.*** **Statewide HIT Taskforce: Facilitated Current State Assessment** (*July 2016 – September 2016*) *A facilitated current-state assessment of HIT for participating members of the IDNs will allow for the creation of a gap analysis at both the IDN and State levels. This data collection will feed into a facilitated statewide discussion regarding required, desired, and optional HIT infrastructure.* *Key work steps in this phase include:* a. Develop standardized current-state assessment tool. This tool will reference the ONC's 2016 Interoperability Standards Advisory. b. Conduct an IDN-member assessment of existing and scheduled HIT efforts and develop a statewide report. c. Taskforce or 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 demonstration objectives. ***Phase 2.*** **Statewide HIT Taskforce: Works Toward Consensus on a Set of Minimally Required, Desired, and Optional HIT HIE Infrastructure Projects for IDNs to Pursue** (*October 2016 – March 2017*) *In order to achieve alignment across IDNs, each IDN will participate in a facilitated, statewide consensus development process to determine the 1) minimally required, 2) desired, and 3) optional HIT infrastructure projects that IDNs should pursue. Once this alignment is attained, each IDN will develop and implement its own IDN-specific HIT implementation plan. HIT governance practices will also be examined in the context of seeking HIT governance compatibility across IDNs.*

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

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

[4] https://ecqi.healthit.gov/ecqm

Each IDN will develop a HIT implementation plan and timeline that will be approved by the State in order for the IDN to be eligible for incentive payments associated with this project. The State will be providing additional information about the format and requirements related to this plan.

The plan will allow for regional differences in HIT capacity, prior investment, and future plans. The implementation plan will build upon the Assessment and Consensus phases and work to reduce the HIT gaps identified in the Project Objective section of this document. There is expected to be a "floor requirement" and a "stretch goal" for each IDN plan so that each IDN shows progress over the five-year period, based on identified process milestones. These plans will be reviewed and approved prior to the State authorizing use of DSRIP funds for implementation.

a. At a minimum, the HIE integration plan component of the IDN's HIT implementation plan will include the following IDN provider(s): hospital, CMHC, community mental health providers, primary care, SUD, and DRF participants[5]. The HIE integration plan will also include New Hampshire Hospital and state the level of anticipated HIE integration with other IDN participants such as County nursing home, County correction facility, developmental disability agency, etc.
b. The IDN's HIT implementation plan will show, at a minimum, how and when all of an IDN's HIE participants will be utilizing ONC Certified Technologies and functions, and adhering to the ONC's 2016 Interoperability Standards Advisory.
c. The IDN's HIT implementation plan will describe how certain key population health management capabilities will be supported, such as individual and community risk assessments, care coordination and care management, health care transitions support, and quality measurement.
d. The IDN's HIT implementation plan will describe the clinical and financial analytic systems' required inputs and outputs, using the State-approved, interoperable standard.
e. The IDN's HIT implementation plan may include concepts and components that go beyond the HIT gaps identified in the Project Objective section of this document if they can demonstrate overall value to the DSRIP Demonstration implementation.

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

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

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

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

Project Group B: Core Competency Project

Mandatory for All IDNs

Project Pathway	Core Competency
Project ID	**B1**
Project Title	**B1: Integrated Healthcare**
Project Objective	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. This project will support and incentivize primary care and behavioral health providers to progress along a path from their current state of practice toward the highest feasible level of integrated care based on the approach described in SAMHSA's Standard Framework for Levels of Integrated Healthcare. The goal of integrating these services is to build a delivery system that effectively and efficiently prevents, treats and manages acute and chronic behavioral health and physical illnesses across multiple providers and sites of service. Implementing this strategy will materially impact the IDN's ability to achieve key demonstration goals: reduce avoidable acute care admissions and ED utilization, and measurably improve the health status for Medicaid beneficiaries and other state residents.
Target Population	Beneficiaries with behavioral health conditions *or at risk for* such conditions will be the primary sub-population expected to benefit from the project.
Target Participating Organizations	Organizations or individual IDN network providers who provide primary care, mental health services, substance misuse/SUD services, social support services providers
Related Projects	• This project represents the foundational core competencies for primary care and behavioral health providers across each IDN network. As such, the project requirements must be implemented in coordination with all other demonstration projects, including Project A1 (Behavioral Health Workforce Capacity Development) and A2 (HIT Infrastructure to Support Integration). • This project must also be closely coordinated with the implementation of the three Community-driven Projects
Project Core Components	As explained in more detail below, under this project each IDN will provide training and support to its primary care practices, community mental health centers, and other network medical and behavioral health providers in becoming a "coordinated care practice" or an "integrated care practice," depending on what is practical given the practice's current level of integration, patient panel size and risk profile, and available resources. **Definitions**

	"Integrated Healthcare" is defined for this project as employing strategies and tactics within primary care and behavioral health practices that will measurably enhance collaboration, (defined as how communication flows among primary care and BH providers and support staff) and integration (defined as how services are delivered and practices are organized and managed). **Two Tiers of Integration: *Coordinated Care Practice* and *Integrated Care Practice*** The project has been designed to balance a) the need to promote integrated health across as many organizations in an IDN as possible with b) the reality that providers vary in scale and current baseline levels of integration. Some providers—in particular some FQHCs and CMHCs—are already providing highly integrated primary, mental health, and SUD care, while other practices have not yet begun this work or lack the size and scale to support the technology and staffing required to integrate care. IDNs will work with network primary care and BH providers to assist them in securing designation as a *Coordinated Care Practice* or an *Integrated Practice*. In advancing along the integration continuum, *all* primary care and behavioral health practices within an IDN are expected to meet 'Coordinated Care Practice' designation. All such providers will be expected to progress as far as feasibly possible toward Integrated Practice designation during the demonstration period. As part of its Project Plan, IDNs also will develop the criteria used to identify practices within the IDN that will meet the additional requirements necessary for *Integrated Care Practice* designation. As part of the planning process in the first half of 2017, IDNs will work with their primary care and BH providers to (a) assess their current state of practice against the designation requirements to identify gaps and (b) to define steps and resources needed to achieve the designation(s) judged to be feasible by the provider and the IDN during the period of the demonstration. ***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: o Documented work flow that ensures timely communication of a defined set of clinical and other information critical to diagnosis, treatment and management of care. It is expected that communication be enabled via electronic means (e.g., shared EHR or coordinated care management system) or that providers are advancing along a continuum towards electronic communication. o On behalf of patients with significant behavioral health conditions or chronic conditions, regularly scheduled (minimum monthly) core team (plus other providers as needed) case conferences. o Documented workflows that incorporate a communication plan inclusive of protocols related to what information is provided to treatment providers, what is available to community based organizations and how privacy will be protected. Closed-loop referral capabilities (electronic or non-electronic). *Standardized workflows and protocols* • Written roles, responsibilities, and workflows for core team members • Protocols to ensure safe care transitions from institutional settings back to primary care, behavioral health and social support service providers. • Intake procedures that include systematically solicit patient consent to confidentially share information among providers **Additional *Integrated Practice* designation requirements:** • All of the requirements for the Coordinated Care Practice designation above • Adoption of *both* of the following evidence-based interventions: 1. Medication-assisted treatment (MAT) 2. Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (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*) **<u>Jul-Dec 2017 Reporting Period</u>** **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

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	The project requires implementation of a three-phase model, based on the evidence-based Critical Time Intervention program. Each of the phases is approximately three months. The intervention is led by a single bachelor or master's degree caseworker trained in CTI and supervised by a mental health professional. Key elements of the project include the following: **Phase 1:** The case worker provides support and begins to connect client to providers and agencies that will gradually assume the primary support role. During Phase 1, the case worker: • Meets client prior to discharge • Collaborates with the mental health professional and primary care provider (including VA providers for veterans dually enrolled in VA care and Medicaid care) on client assessment(s) and, with client, develop and document a care transition plan • Makes home visits to meet with client and caregivers, teach conflict resolution skills, and provide support as needed • Identifies and meets with existing supports and introduces the client to new supports as needed.

	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 client to increase levels of responsibility. **Phase 3**: The caseworker completes the termination of CTI services with the client's support network safely in place. More information can be found at: http://www.criticaltime.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 (as identified in the approved IDN Project Plan) have achieved the following process milestones during, or in advance of, the timeframes noted. **Jan-Jun 2017 Reporting Period** **1. Development of implementation plan, which includes:** a. Implementation timeline b. Project budget c. Work force plan: CTI staffing plan; recruitment and retention strategies d. Projected annual client engagement volumes e. Key organizational/ provider participants **2. Design and development of clinical services infrastructure, which includes identification or development of:** a. Standardized protocols for Care Transition Team model including patient identification criteria, standardized care transition plan, case worker guidelines, and standard processes for each of the program's three phases b. Roles and responsibilities for CTI team members c. Training plan d. Training curricula e. Agreements with collaborating organizations, including New Hampshire Hospital if applicable

f. Evaluation plan, including metrics that will be used to measure program impact
g. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements (e.g., re-hospitalization data)

July-Dec 2017 Reporting Period

3. Operationalization of program

a. Implementation of workforce plan
b. Deployment of training plan
c. Implementation of any required updates to clinical protocols, or other operating policies and procedures
d. Use of assessment , treatment, management and referral protocols

4. Initiation of data reporting

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

Jan-Jun 2018 Reporting Period

5. Ongoing data reporting

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

Jul-Dec 2018 Reporting Period

6. Ongoing data reporting

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

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	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: 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. 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.
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	**Core elements of the community re-entry program include:** • **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: o 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. o 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. o 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 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. • **Staffing:** The integrated care team will be multi-disciplinary and serve between 25-50 individuals, depending on severity. The staff should include: o 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: o Mental health professional (e.g., LCSW, Psychologist) who will support and supervise the care coordinator o Consulting psychiatrist to design medication regimen and serve as an advisor to the team o Primary care provider (PCP) o For youth, family support specialists
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. **<u>Jan-Jun 2017 Reporting Period</u>** **1. Development of implementation plan, which includes:** a. Implementation timeline b. Project budget c. Work force plan: staffing plan; recruitment and retention strategies d. Projected annual client engagement volumes e. Key organizational/ provider participants **2. Design and development of clinical services infrastructure, which includes identification or development of:**

a. Standardized assessment tool(s)
b. Patient assessment, treatment, management, and referral protocols
c. Roles and responsibilities for team members
d. Training plan
e. Training curricula
f. Agreements with collaborating organizations, 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 **<u>Jul-Dec 2018 Reporting Period</u>** **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	Care Transitions
Project ID	**C3**
Project Title	**C3: Supportive Housing**
Project Objective	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. 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. It is important to note that the NH DSRIP Demonstration 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.
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 Components	Core components of the supportive housing project include the following: 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: • 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). • 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. 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.
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. **<u>Jan-Jun 2017 Reporting Period</u>** • **Development of implementation plan, which includes:** o Implementation timeline o Project budget o Work force plan: staffing plan; recruitment and retention strategies o Projected annual client engagement volumes o Key organizational/ provider participants, including housing agencies/resources • **Design and development of clinical services infrastructure, which includes identification or development of:** o 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 **<u>July-Dec 2017 Reporting Period</u>** • **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 **<u>Jan-Jun 2018 Reporting Period</u>** • **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 **<u>Jul-Dec 2018 Reporting Period</u>** • **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, including annual evaluation of fidelity to evidence-supported program elements

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 addition, 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	• Behavioral health, primary care or specialty providers
Related Projects	• IDNs implementing this project should coordinate with and build on the Core Competencies being developed as part of Project B1 (integration of behavioral health and primary care)
Project Core Components	**Definitions:** • 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. **Implementation requirements for organizations participating in this project include:** • 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) • 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) **Core elements of MAT programs implemented by organizations participating in this project include:** • 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: o Pregnant women o Individuals that have experienced an overdose in past 30 days o IV drug users o Custodial parents of minor children o People who are employed 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 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

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.
	
	<u>Jan-Jun 2017 Reporting Period</u>
	
	• **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 an 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	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. 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. **Core elements of the project include:** • 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 o Formal, written peer staff training requirements, and training compliance monitoring and peer staff supported in obtaining required training and monitored for compliance. o 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 component of peer to peer supervision or co-supervision. • Requirements specific to peer support agencies: ○ 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.
Additional Information	Agencies providing peer *recovery* support services are required to be enrolled in Medicaid as one of three provider types: • 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 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
Proposed 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. **<u>Jan-Jun 2017 Reporting Period</u>** **7. Development of implementation plan, which includes:** 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

	<u>Jul-Dec 2018 Reporting Period</u> **12. 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, including annual evaluation of fidelity to evidence-supported program elements

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	• Individuals with substance use disorders (with or without co-occurring mental health disorders)
	• Within the target population, priority populations include:
	  ○ Pregnant women
	  ○ Individuals that have experienced an overdose in past 30 days
	  ○ IV drug users
	  ○ Custodial parents of minor children

Target Participating Organizations	Behavioral health organizations seeking to expand service options
Related Projects	• IDNs implementing this project should coordinate with and build on the Core Competencies being required as part of Project B1 (integration of behavioral health and primary care), including the use of screening, brief intervention, and referral to treatment (SBIRT) • 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	**IDNs implementing this project will expand capacity to deliver the following three types of SUD treatment/recovery services.**
	
	1. At least 1 higher intensity service:
	  ○ Intensive Outpatient (IOP)
	  ○ Partial Hospitalization (PH)
	  ○ Non-hospital based residential treatment services

	Ambulatory and non-hospital inpatient medically monitored residential, as well as hospital inpatient medically managed withdrawal management services, should be offered concurrent or in tandem, as indicated, with treatment services for mental health (MH), substance use (SUD) and co-occurring (COD) disorders. Medication assisted treatment services (MAT) are also a critical component for effectively addressing substance used disorders (see project D1, specifically focused on medication assisted treatment). Providers will provide concurrent treatment of co-occurring tobacco use disorder. 2. **Regular outpatient counseling for substance use disorders** (and/or co-occurring disorders), provided by qualified practitioners, for individuals with lower levels of acuity broadly across the spectrum of health and social service programs within the IDN.
Process Milestones	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. **<u>Jan-Jun 2017 Reporting Period</u>** 1. **Development of implementation plan, which includes:** a. Implementation timeline b. Project budget c. Work force plan: staffing plan; recruitment and retention strategies d. Projected annual client engagement volumes e. Key organizational/ provider participants 2. **Design and development of clinical services infrastructure, which includes identification or development of:** a. Standardized assessment tool(s) b. Patient assessment, treatment, management, and referral protocols c. Roles and responsibilities for team members d. Training plan e. Training curricula

f. Agreements with collaborating organizations
g. Evaluation plan, including metrics that will be used to measure program impact
h. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

July-Dec 2017 Reporting Period

3. Operationalization of program

a. Implementation of workforce plan
b. Deployment of training plan
c. Implementation of any required updates to clinical protocols, or other operating policies and procedures
d. Use of assessment , treatment, management and referral protocols

4. Initiation of data reporting

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

Jan-Jun 2018 Reporting Period

5. Ongoing data reporting

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

Jul-Dec 2018 Reporting Period

	6. Ongoing data reporting a. Number of individuals served (during reporting period and cumulative), vs. projected b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected c. Staff vacancy and turnover rate for period and cumulative vs projected d. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements
Additional Information	Additional information on the treatment of substance use and co-occurring disorders can be found at: • The Substance Abuse Mental Health Services Administration (SAMHSA) Treatment Improvement Protocols (TIPs) 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-

Project Pathway	Capacity Building
Project ID	**D4**
Project Title	**D4: Multidisciplinary Nursing Home Behavioral Health Service Team**
Project Objective	*Background* 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. *Objective* 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.
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	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. • 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.

	o Psychiatric and medication evaluation, monitoring and treatment o Medical evaluation, monitoring and treatment 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 Other project core components include: • 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	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** **7. 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 **8. Design and development of clinical services infrastructure, which includes identification or development of:**

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 **<u>Jul-Dec 2018 Reporting Period</u>** **12. 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

Community Driven Projects: Integration-focused

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 addition, 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	• 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	**Key elements of wellness programs to be implemented as part of this project:** • 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: o Development of an individualized, client-centered wellness assessment that addresses physical activity, nutrition and tobacco use o Development of an individualized fitness and diet plan reflecting client goals o 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 o 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 • 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 **IDNs implementing this project may base its wellness interventions on the approaches of the following evidence-informed programs:** • InSHAPE • National Diabetes Prevention Program • Diabetes Self-Management Program • Bright Futures • Dimensions Tobacco Free Toolkit for Healthcare Providers
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. **<u>Jan-Jun 2017 Reporting Period</u>** **13. Development of implementation plan, which includes:** 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 **14. Design and development of clinical services infrastructure, which includes identification or development of:** 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 d. Impact measures as defined in evaluation plan **Jul-Dec 2018 Reporting Period** **18. 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	More information can be found at: http://www.cdc.gov/diabetes/prevention/index.html http://patienteducation.stanford.edu/programs/cdsmp.html www.integration.samhsa.gov/health-wellness-strategies/tobacco-cessation-2smokingcessationleadership.ucsf.edu/behavioral-health

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	*School districts:* 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 *School system staff:* 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 *Other IDN providers:* pediatric health care professionals, mental health providers, SUD providers *Early intervention program providers*, if applicable.
Related Projects	Project E3 (Substance use Treatment and Recovery Program for Adolescents and Young Adults)
Project Core Components	**This project involves the implementation of an evidence based model, or models, for:** • 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 IDNs must develop these models and select the appropriate screening/assessment tools in collaboration with (and with the full support of) the school districts. **The project includes the following core elements:** • Designation of a School Intervention Team composed of selected members of the school staff • Development and deployment of education/training curricula for *identified school-based staff* to strengthen skills in:

	Screening and prevention ○ The use of evidence based screening tools (CRAFFT, GAAD7, PHQ2, PHQ9) and intervention techniques such as motivational interviewing to engage the students in the care process ○ 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. ***Brief Intervention (for substance misuse)*** ○ 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. ***Referral to Treatment*** ○ Properly referring children and adolescents with higher acuity needs to professionals for evaluation and treatment services • Development of written agreements that include referral protocols for professional evaluation and treatment services including: ○ 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
Proposed 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 (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	*Background* 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 that 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. *Objective* 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.
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	**IDNs will select organizations to participate in this project. Participating organizations will implement the following core project elements:** *Expansion of capacity to deliver treatment/intervention services* • 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: ○ 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 appropriate An 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

Process Milestones	**<u>Jan-Jun 2017 Reporting Period</u>** 1. **Development of implementation plan, which includes:** 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:** 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 for example 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** 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 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 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 **<u>Jan-Jun 2018 Reporting Period</u>** 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 **<u>Jul-Dec 2018 Reporting Period</u>** 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	• 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	• 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	**Integrated Treatment for Co-Occurring Disorders is an evidence based treatment program that is built upon seven principles:** 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

	Programs following this approach should include the following key elements: *Multi-disciplinary team* • 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 *Robust training and on SUD and serious mental illness* • Training program for treatment specialists based on SAMHSA model for training frontline staff in Integrated Treatment for Co-Occurring Disorders *Assessment and intervention* • 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 *Technology support* • 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. **<u>Jan-Jun 2017 Reporting Period</u>** **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 **<u>July-Dec 2017 Reporting Period</u>** **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 **<u>Jan-Jun 2018 Reporting Period</u>** **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 **<u>Jul-Dec 2018 Reporting Period</u>** **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	• Adults (18 years or older): individuals with behavioral health disorders (specifically, serious mental illness or Substance Use Disorders, including opioid addiction) with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors (such as homelessness) that are barriers to community living and well-being • Children (< 18 years): children diagnosed with chronic serious emotional disturbance • Developmentally Disabled (DD) population Aged Blind and Disabled (ABD) population with co-occurring behavioral health disorders
Target Participating Organizations	• Primary care providers • Behavioral health providers (mental health and SUD) • Community-based social support service organizations
Related Projects	• IDNs implementing this project should coordinate with and build on the Core Competencies being developed as part of Project B1 (integration of behavioral health and primary care) • Health information technology (HIT) requirements for this project should be incorporated into the IDN's HIT planning process in conjunction with Project A2 (HIT Infrastructure to Support Integration) • Workforce requirements for this project should be incorporated into the IDN's Workforce Capacity Development Implementation Plan in conjunction with Project A1 (Behavioral Health Workforce Capacity Development)
Project Core Components	• IDNs implementing this project will define its specific care coordination models and exact target populations; however, core required elements of any model include: o Identified care teams that include care coordinator/managers, primary care providers, behavioral health providers o Systematic strategies to identify and intervene with target population o A comprehensive core assessment and a care plan for each enrolled patient, updated on a regular basis

	○ 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 ○ 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	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. **<u>Jan-Jun 2017 Reporting Period</u>** **1. Development of implementation plan, which includes:** a. Implementation timeline b. Project budget c. Work force plan: staffing plan; recruitment and retention strategies d. Projected annual client engagement volumes e. Key organizational/ provider participants **2. Design and development of clinical services infrastructure, which includes identification or development of:** a. Description of target population and eligibility criteria, including rationale for intervention with this target population that aligns with the goals of the Transformation Demonstration b. Standardized assessment tool(s) c. Patient assessment, treatment, management, and referral protocols, including: i. Method for rapidly identifying and engaging the target population in community delivered care or self-management strategies

ii. Model for ongoing care coordination/management and intervention with the target population, indicating strategies and mechanism through which the model will improve management of the chronic conditions

d. Roles and responsibilities for care team members
e. Training plan
f. Training curricula, including standard set of care coordinator/manager knowledge and skills requirements and qualified training resources for care managers/coordinators
g. Agreements with collaborating organizations, including community-based social support organizations
h. Evaluation plan, including metrics that will be used to measure program impact (e.g., number of successful linkages to social support services, change in utilization of ED and inpatient services for those enrolled/active for more than 3 months)
i. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

July-Dec 2017 Reporting Period

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

Jan-Jun 2018 Reporting Period

	5. Ongoing data reporting a. Number of individuals served (during reporting period and cumulative), vs. projected b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected c. Staff vacancy and turnover rate for period and cumulative vs projected d. Impact measures as defined in evaluation plan **Jul-Dec 2018 Reporting Period** **6. Ongoing data reporting** a. Number of individuals served (during reporting period and cumulative), vs. projected b. Number of staff recruited and trained (during reporting period and cumulative), vs. projected c. Staff vacancy and turnover rate for period and cumulative vs projected d. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements

Outcome Metric Specifications

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 establish a performance goal for each of these metrics and will measure IDN improvement from a baseline towards this goal to evaluate whether or not the IDN has achieved the metric improvement target each semi-annual reporting period. Performance goals will be based on the 85th percentile of performance within the state during the baseline period.

Each IDN will have its own baseline starting point, based on historical data that will be generated after IDN networks are finalized and it is possible to establish an IDN-specific baseline. For certain measures, including newly created measures, baseline data will be collected during 2017, at which point the performance goal and annual IDN improvement targets will be established for 2019 and 2020.
The state will set annual improvement targets for IDN metrics that reflect annual progress towards closing the relative gap by 15% between the baseline performance of each IDN and the goal for each metric. These data will be used to determine the size of the "gap to goal" for the purpose of setting annual improvement targets. This methodology is further explained through the following illustrative example:

Illustrative Example:
Metric: Potentially Preventable ER Visits for BH Population (visits/1,000)
Goal: 125.4 visits/1,000 (85th percentile of baseline IDN performance)

In this example, IDN #1 has a baseline preventable ED visit rate of 210.2 visits/1,000. The gap between 210.2 visits/1,000 and the 85th percentile goal of 125.4 visits/1,000 is 84.8 visits/1,000. The IDN's annual improvement targets will be set to require that the IDN close this 84.8 visits/1,000 gap by 15% (or 12.7 visits/1,000) each year. IDN #2, on the other hand, has a baseline performance level of 180.7 visits/1,000. Therefore, the 'gap-to-goal' for IDN #2 is 55.3 visits/1,000 (difference between 180.7 visits/1,000 and the goal of 125.4 visits/1,000). The IDN's annual improvement targets will be set to require that the IDN close this 55.3 visits/1,000 gap by 15% (or 8.3 visits/1,000) per year.
In cases where IDN performance meets or exceeds 85th percentile of performance within the state, annual improvement targets will reflect a 5% annual improvement in the metric from the IDN's prior year baseline, up to a maximum to be determined by the NH DHHS Office of Quality Assurance and Improvement. In other words, if IDN #3 has a baseline performance level of 123.2 visits/1,000 in the example above, the IDN already exceeds the 85th percentile goal of 125.4 visits/1,000. Therefore, rather than following a 'gap-to-goal' target-setting methodology, this IDN would be required to improve performance on this metric by 5% per year, up to a maximum to be determined by the NH DHHS Office of

Quality Assurance and Improvement. A 5% absolute improvement from a baseline level of 123.2 visits/1,000 would result in a target of 117.4 visits/1,000 for the first performance measurement year.

In other cases, baseline performance on a metric across IDNs may be too similar/concentrated or an IDN's baseline performance may already be too close to the 85th percentile goal to allow for meaningful improvement using a 'gap-to-goal' methodology. In these cases, the state will use a comparable national benchmark or require 5% annual improvement in the metric from prior year's baseline in establishing the performance goal.

Table 1: Transformation Initiative Outcome Metrics

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	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 PCR 2017	IDN; Claims/ Encounters and Non-Claim Discharges from NHH for age 21-64	Per HEDIS	Adult (18+) BH/SUD Population as of end of data reporting period	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 FUA	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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 FUM	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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 FUH 2017 (w/Addition of IMD discharges)	DHHS; Claims/ Encounters/ NHH Discharge Data	Based on HEDIS FUH (w/addition of any IMD discharges)	Based on HEDIS FUH (w/addition of any IMD discharges)	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 FUH 2017 (w/Addition of IMD discharges)	DHHS; Claims/ Encounters/ NHH Discharge Data	Based on HEDIS FUH (w/addition of any IMD discharges)	Based on HEDIS FUH (w/addition of any IMD discharges)	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	Numerator	Denominator	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	Population screened and if positive follow up plan documented in EHR	Population Age 12+ as of end of data reporting period	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 2017	IDN; IDN EHR Output	Per CMS	Per CMS	Semi-Annually		-	P4R	P4P	P4P	All
Patient Reported Experience of Care	**Global Score for Mini-CAHPS Satisfaction Survey at IDN Level for kids and adults[8]**	Subset of Health Plan CAHPS 5.0 questions	DHHS; DHHS Mini-CAHPS Survey	Average responses using NCQA adapted ranking methods	Weighted survey respondents (parents and adults combined)	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	Number with appropriate assessment documented in EHR	Population Age 12+ as of end of data reporting period	Semi-Annual	X	-	P4R	P4P	P4P	B1, C1,C2, D1, E3, E4, E5

[8] This measure will reflect Composite Customer Satisfaction following NCQA Plan Ranking methodology, which combines the Ease of Getting Care and Satisfaction with Physicians question sets (excluding health plan customer service questions). IDN targets will be established based on the weighted points required to achieve a ranking of 4 out of 5 on NCQA scale for Medicaid plans. IDNs that exceed this goal, would be expected to increase by point levels by 5% per year thereafter until they reach the points needed to achieve a ranking of 5. IDNs that achieve a ranking of 5 would need to maintain these points to continue to receive incentive payments.

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	Periodicity	Statewide measure?[6]	Active Year(s)[7]				Associated Projects
								2017	2018	2019	2020	
Physical Health/Primary Care Clinical Quality/Screening and Assessment	**Global score for selected general HEDIS physical health measures, adapted for BH population**	HEDIS (adapted) 2017 CBP, SPC, CDC, SPD, PCE, MMA	IDN/DHHS; Claims/ Encounters/IDN EHR Report	Average responses using NCQA adapted ranking methods	Adult (18+) BH/SUD Population as of end of data reporting period	Annual		-	P4R	P4P	P4P	B1, C1, C2, D1, D2, D4, E1, E3, E4
BH Care Clinical	**Global score for selected BH-focused HEDIS measures**	HEDIS 2017 AMM, ADD, SSD, SMD, SMC, SAA, APM	IDN/DHHS; Claims/ Encounters/IDN EHR Report	Average responses using NCQA adapted ranking methods	Per HEDIS	Annual			P4P	P4P	P4P	B1, C1, C2, D1, D2, D4, E1, E3, E4
Physical Health/Primary Care Clinical Quality/Screening and Assessment	**Percent of BH Population With All Recommended USPSTF A&B Services (See Table 2 Supplemental Specifications)**	See Table 2 Supplemental Specifications	IDN; Claims/ Encounters/IDN EHR Report	Number with appropriate service documented in EHR	BH/SUD population as of end of data reporting period	Annual		-	P4P	P4P	P4P	B1, D4
Physical Health/Primary Care Clinical Quality/Screening and Assessment	**Recommended Adolescent (age 12-21) Well Care visits**	HEDIS Hybrid 2017 AWC	DHHS; Claims/ Encounters & IDN EHR Report	Per HEDIS	Per HEDIS	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**	NQF 0027 PQRI 115 2017	IDN; IDN EHR Report	Per PQRI	Per PQRI	Semi-Annual		-	P4R	P4P	P4P	All
Population Level Utilization	**Frequent (4+ per year) ER Visits Users for BH Population**	DHHS Measure	DHHS; Claims/ Encounters	Number with 4 or more outpatient ED visits in the prior year	BH/SUD population as of end of data reporting period	Semi-Annual		-	P4P	P4P	P4P	All
Population Level Utilization	**Potentially Preventable ER Visits for BH Population and Total Population**	Adapted from DHHS MCO reporting AMBCARE Measure	DHHS; Claims/ Encounters	Per DHHS specification for MCO reporting	50/50 weighted average of BH/SUD population and rest of population as of	Semi-Annual	X	-	P4P	P4P	P4P	All

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	Periodicity	Statewide measure?[6]	Active Year(s)[7]				Associated Projects
								2017	2018	2019	2020	
					end of data reporting period							
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**	2017 PQA	DHHS; Claims/ Encounters	Population screened and if positive follow up plan documented in EHR	Population Age 12+ as of end of data reporting period	Semi-Annual		-	P4P	P4P	P4P	B1, C1, C2, C3, D1, D2, D3, E3, E4, E5
Workforce Capacity	**Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)**	HEDIS IET 2017	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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 IET 2017	DHHS; Claims/ Encounters	Per HEDIS	Per HEDIS	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	Number who actually had visit within 7 days of referral	Population new to CMHC system per Phoenix data who had intake appointment	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; DHHS CMHC Phoenix Encounter Data Reporting System	Number who had first treatment visit within 7 days of intake appointment	Population new to CMHC system per Phoenix data who had intake appointment and were determined eligible for CMHC services	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; DHHS CMHC Phoenix	Number who had first psychiatrist visit within 30	Population new to CMHC system per Phoenix data	Semi-Annual		-	-	P4P	P4P	B1, C1, C2, C3, E5

Measure Category	Measure	Measure Steward and Specification	Reporting Responsibility; Measure Source Data	Numerator	Denominator	Periodicity	Statewide measure?[6]	Active Year(s)[7]				Associated Projects
								2017	2018	2019	2020	
			Encounter Data Reporting System	days of intake appointment	who had intake appointment and were determined eligible for CMHC services							

Table 2: Supplemental Specifications for "Percent of BH Population With All Recommended USPSTF A&B Services" Composite Measure (see Table 1)

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
Substance Use Disorder	Screening		Alcohol		Men, Women	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Substance Use Disorder	Early Treatment	Counseling	Tobacco		Men, Women	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Substance Use Disorder	Early Treatment	Counseling	Tobacco		Pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Substance Use Disorder	Early Treatment	Counseling	Tobacco		Adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
Mental Health	Screening		Depression		Adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Mental Health	Screening		Depression		Men, Women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Mental Health	Screening		Intimate Partner Violence		Women	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Physical Health	Screening		CV	Blood Pressure		The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
Physical Health	Screening		CV	Cholesterol	Men	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.
Physical Health	Screening		CV	Cholesterol	Men	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		CV	Cholesterol	Women	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		CV	Cholesterol	Women	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		CV	Obesity	Men, women	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Physical Health	Screening		Cancer	Breast Cancer	Women	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
Physical Health	Screening		Cancer	Cervical	Women	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
Physical Health	Screening		Cancer	Colon	Men, women	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.
Physical Health	Screening		Cancer	Lung	Men, women	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Physical Health	Screening		Diabetes	Obesity	Men, women	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Physical Health	Screening		STD	Gonorrhea	Women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Physical Health	Screening		STD	Hep B	Men, women, adolescents	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Physical Health	Screening		STD	Hep B	Pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Physical Health	Screening		STD	HIV	Men, women, adolescents	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
Physical Health	Screening		STD	HIV	Pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Physical Health	Screening		STD	Hep C	Men, women	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
						one-time screening for HCV infection to adults born between 1945 and 1965.
Physical Health	Screening		STD	Syphilis	Men, women	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Physical Health	Screening		STD	Syphilis	Women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
Physical Health	Early Treatment			Aspirin use	Men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Physical Health	Early Treatment		CV	Aspirin use	Women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Physical Health	Early Treatment	Counseling	Obesity		Men, women	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
Physical Health	Early Treatment	Counseling	Obesity		Children, adolescents	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Physical Health	Early Treatment	Counseling	STD		Men, women, adolescents	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.

ATTACHMENT D: DSRIP PROGRAM FUNDING AND MECHANICS PROTOCOL

New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration
Approved July 20, 2016

I. Preface

a) Delivery System Reform Incentive Payment Fund

On January 5, 2016, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's request for a section 1115(a) Medicaid demonstration (hereinafter "demonstration") entitled *Building Capacity for Transformation, a Delivery System Reform Incentive Payment (DSRIP) Program*. Under the DSRIP demonstration, the state will make performance-based funding available to regionally-based Integrated Delivery Networks (IDN) that serve Medicaid beneficiaries with the goal of transforming the delivery system for beneficiaries with mental health conditions and/or substance use issues, including opiate abuse. This transformation will be supported by participation of IDNs in Alternative Payment Models (APM) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

The Special Terms and Conditions (STC) of the demonstration set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period.

STC 20 describes the general rules and requirements of the IDN Transformation Fund. The IDN Transformation Fund will be used to make payments to the IDNs that implement projects to further the objectives of the demonstration and that meet milestones described in a state-approved IDN Project Plan.

STC 31 establishes the IDN Project Design and Capacity Building Fund which will be used by IDNs for pre-implementation activities. The dollar amount available for the IDN Project Design and Capacity Building Fund accounts for up to 65 percent of Demonstration Year (DY) 1 funding, or up to $19.5 million. The IDN Project Design and Capacity Building Fund will be used by IDNs to develop specific and comprehensive IDN Project Plans and to begin to develop the capacity and tools required to implement these plans.

b) DSRIP Program Funding and Mechanics Protocol

The requirements specified in the STCs are supplemented by the Quarterly Report Format (Attachment A), the DSHP Claiming Protocol (Attachment B), the DSRIP Planning Protocol (Attachment C), and this DSRIP Program Funding and Mechanics Protocol (Attachment D).

In accordance with STC 27, Section II of the DSRIP Program Funding and Mechanics Protocol (this attachment, Attachment D) describes the structure of IDNs and how beneficiaries are attributed to IDNs; Section III specifies the process by which organizations apply to create IDNs; Section IV provides an overview of projects, metrics, and metric targets (see Attachment C for more detail); Section V describes the incentive funding methodology; Section VI specifies IDN reporting requirements; Section VI outlines other state oversight activities; Section VIII identifies Statewide accountability metrics and the process by which unearned IDN funds are handled; and Section IX describes the demonstration's Mid-Point Assessment.

In accordance with STC 27, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

c) Supporting Project and Metrics Specification Guide

This attachment will be supplemented by a Project and Metrics Specification Guide developed by the state. This Guide will provide additional details and requirements related to the IDN projects and will assist IDNs in developing their Project Plans, described in Section III Below.

II. Integrated Delivery Networks

a) Introduction

Under the demonstration, a broad array of health and social service providers within geographic regions across the state will create Integrated Delivery Networks (IDNs) capable of implementing evidence-supported programs that address the needs of Medicaid beneficiaries with behavioral health conditions. IDNs are the only entities that are eligible to receive incentive payments from the IDN Transformation Fund or the Design and Capacity Building Fund, as described in STC 21. An organization seeking to participate in the demonstration and receive incentive or design and capacity building payments must do so through an IDN.

IDN partners will include but not be limited to: Federally Qualified Health Centers (FQHC), and/or Community Health Centers or Rural Health Clinics where available within each defined region, Community Mental Health Centers (CMHC), other mental health providers, substance use disorder (SUD) providers (including recovery providers), hospitals, independent primary

care providers (PCP), psychiatrists, psychologists and other behaviorists, medical specialists, county organizations representing nursing facilities and correctional systems, peer and family supports counselors, and multiple community-based social support agencies that serve the target population in a region or regions.

b) IDN Service Regions

IDNs will be organized around seven Service Regions throughout the state. These Service Regions will include one or more of the thirteen Regional Public Health Networks (RPHN) in New Hampshire, as listed in Table 1 below. The 13 New Hampshire RPHNs were established in 2013 to ensure coordinated and comprehensive delivery of essential public health services regionally. Through single contracts with 13 agencies who serve as the host entity for each of the networks, New Hampshire DHHS funds these agencies to convene, coordinate, and facilitate an ongoing network of partners to address regional public health needs. The purpose of the RPHNs is to integrate multiple public health initiatives and services into a common network of community stakeholders. The IDN Service Regions were designed around the RPHNs, and IDNs are expected to coordinate closely with RPHN agencies.

Table 1: IDN Service Regions

Service Region	RPHNs Included
1. Monadnock, Sullivan, Upper Valley	Greater Monadnock, Greater Sullivan County, Upper Valley
2. Capital	Capital Area
3. Nashua	Greater Nashua
4. Derry & Manchester	Greater Derry, Greater Manchester
5. Central, Winnipesaukee	Central New Hampshire, Winnipesaukee
6. Seacoast & Strafford	Strafford County, Seacoast
7. North Country & Carroll	North Country, Carroll County

More than one IDN can serve in a region, although providers and social service agencies are strongly encouraged to collaborate and build a single IDN per region when feasible, particularly for less populated regions. As described in detail in Section III, IDNs will be selected through an IDN application process. When evaluating applications, the state and Independent Assessor will

consider the extent to which applicants have developed an efficient, collaborative approach to serving their regions.

c) IDN Composition and Provider Participation Guidelines

Each IDN will consist of partner organizations and an administrative lead. As described in Section III, the diversity and expertise of participating providers and social service organizations will be important criteria in evaluating IDN applications. The IDN partners must together be able to provide the full spectrum of care and related social services that might be needed by an individual with a behavioral health condition. As such, at a minimum each Integrated Delivery Network must include:

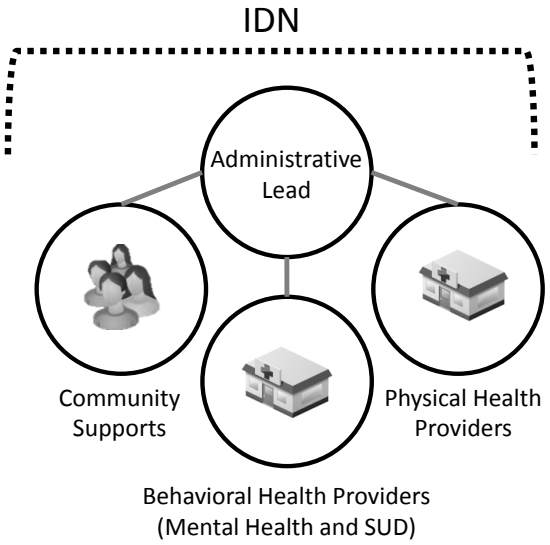
- Primary care practices and facilities, serving the majority of Medicaid beneficiaries
- Substance use disorder (SUD) providers, including recovery providers, serving the majority of Medicaid beneficiaries
- Regional Public Health Network host agencies
- One or more Regional Community Mental Health Centers
- Peer-based support and/or community health workers from across the full spectrum of care
- One or more hospitals
- One or more Federally Qualified Health Centers, Community Health Centers or Rural Health Clinics where available within a defined region
- Multiple community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations, such as transportation, housing, employment services, financial assistance, childcare, veterans services, community supports, legal assistance, etc.
- County facilities, such as nursing facilities and correctional institutions

Some organizations serve Medicaid beneficiaries across multiple IDN Service Regions and may be critical to the success of multiple IDNs. Therefore, organizations are permitted to participate in multiple IDNs. However, in accordance with STC 22, as part of its IDN Project Plan (described further in Section III and in Attachment C) IDNs will be required to describe clear business relationships among participating organizations, including a joint budgeting and funding distribution plan that specifies in advance the methodology for distributing incentive funding to participating partner organizations, as well as mechanisms to ensure a partner participating in multiple IDNs does not receive duplicative payments for serving the same beneficiary through a project activity.

d) *IDN Administrative Leads*

Each IDN must designate an Administrative Lead from among the partner organizations that constitute the IDN. The Administrative Lead will submit a single IDN application on behalf of the partner organizations, and serve as the single point of accountability to the state. Its responsibilities include serving as a coordinating entity for the partners in planning and implementing projects; receiving and distributing funds to IDN partners in accordance with the funding methodology (described in III(c) below); collaborating with partners in IDN leadership and oversight; leading data and reporting responsibilities, and complying with all state and CMS reporting requirements.

Figure 1: Integrated Delivery System and Administrative Lead



The Administrative Lead can be any type of provider or organization that participates in the IDN, but it must, at a minimum, meet the following requirements:

- Demonstrate that it has the experience to coordinate transformation efforts in collaboration with partners in the Service Region.
- Show evidence of active working relationships, or the ability to establish such relationships, with diverse entities that will participate in the IDN, including social service organizations and community partners.
- Establish its ability to administer the financial responsibilities of an administrative lead such as by detailing prior experience using financial practices that allow for transparency and accountability and by demonstrating financial stability.
- Specify how it will comply with the IDN reporting requirements and obligations
- Provide consent for audit and oversight by the state and CMS.

e) IDN Governance and IDN Management

As part of its IDN Project Plan development process (described further in Section III and in Attachment C), the IDN Administrative Lead will coordinate a process for establishing a governance structure to facilitate and oversee decision-making.

In establishing an IDN governance structure, the Administrative Lead and other participating organizations must ensure it is consistent with the following principles:

- *Participatory*, i.e., IDN partners have active roles in decision-making processes
- *Accountable*, i.e., Administrative Lead and partners are accountable to each other, with clearly defined mechanisms to facilitate decision-making
- *Flexible*, i.e., within parameters established by DHHS and outlined in the Project Plan template, each IDN can implement a governance structure that works best for it

It is required that an IDN identify a primary governing body (e.g., a Board or Executive Committee) and that this body reflect representation from across all required organization types listed in Section II (c). The primary governing body should be no larger than 15 members (exceptions require written justification). In addition, the overall structure of governance bodies established by the IDN must reflect oversight over the following four domains, at a minimum:

- *Financial governance*, including how decisions about the distribution of funds will be made, the roles and responsibilities of each partner organization, and budget development
- *Clinical governance*, including standard clinical pathways development and strategies for monitoring and managing patient outcomes
- *Data/IT governance*, including data sharing among partners and reporting and monitoring processes
- *Community engagement*, including the processes by which the IDN will engage the community in the development and implementation of the IDN

Furthermore, as part of its Project Plan, each IDN will be required to identify individuals serving the following key management functions:

- Executive Director, or equivalent
- Medical Director, or equivalent
- Financial Director, or equivalent

f) DSRIP Beneficiary Attribution

The demonstration seeks to enable each IDN to improve care for Medicaid beneficiaries at risk for or already diagnosed with behavioral health conditions (mental illness and/or substance use disorder) in and around its Service Region. Every Medicaid beneficiary will be attributable to one, and only one, IDN. Attribution will be used for two primary purposes:

1. As a component of the formula used to determine the maximum five-year IDN Project Funding amount for each IDN, described in more detail in Section V
2. For measurement of IDN performance metrics

The principle of New Hampshire's attribution methodology is that beneficiaries should be attributed to IDNs based on where they currently receive their care, although it is not always possible to identify a beneficiary's current providers. Accordingly, attribution of New Hampshire's eligible Medicaid beneficiaries will be based on the following four factors:

- Use of long-term care facility providers
- Use of mental health / substance use disorder providers, including Community Mental Health Center (CMHC) providers
- Use of primary care providers
- Geographic criteria (when necessary)

Priority will be given to assigning beneficiaries based on their care providers using health care claims and other data available to New Hampshire. When it is not possible to make an assignment based on these factors alone, the attribution algorithm will consider geographic criteria.

The following table provides additional detail on the 5-step logic by which a member will be attributed to an IDN. If the member meets the criteria in a particular step, the member will be attributed to the associated IDN. If the member does not meet the criteria in a particular step, the logic advances to the next step.

Table 2: NH DSRIP Attribution Algorithm

Step	Medicaid Member Status	YES?	NO?
1	Is the member receiving long-term care at a long-term care facility, and is the facility in a single IDN?	*If yes, member is assigned to the facility's affiliated IDN.*	*If no, proceed to step 2.*
2	Is the member a Community Mental Health Center (CMHC) patient, and is the CMHC in a single IDN?	*If yes, member is assigned to the CMHC's affiliated IDN.*	*If no, proceed to step 3.*
3	Has the member received services from a primary care provider, and is the provider in a single IDN? *(Note: identification of primary care provider will based on the member's most recent preventive care claim(s), followed by the most recent E&M office visit or clinic visit codes to FQHCs, RHCs, APRNs, pediatricians, family practice, and internal medicine providers)*	*If yes, member is assigned to the provider's affiliated IDN.*	*If no, proceed to step 4.*
4	Does the member have recent claims for behavioral health or substance use disorder treatment services, and is the most recent provider in a single IDN?	*If yes, member is assigned to the provider's affiliated IDN.*	*If no, proceed to step 5.*
5	Geographic criteria: member is assigned to the IDN based on the IDN Service Area of the member's residence.		

Once the attribution of beneficiaries to IDNs is finalized, the state will calculate the Maximum IDN Project Funding amount for each IDN for the 5-year demonstration period, as described in Section V. This valuation calculation will occur during Year 1 of the demonstration. Attribution may subsequently be updated periodically for the purposes of IDN performance measurement. However, the 5-year Maximum IDN Project Funding will go through a calculation process once during Year 1 of the demonstration and will remain unchanged throughout the demonstration.

For the purposes of collecting sufficient sample sizes for some performance metrics or to allow for risk sharing arrangements under alternative payment models in future years, IDNs may be

aggregated into larger areas, or "zones." When zones are used as the unit of analysis for measuring progress toward milestones, any incentive funds earned will be distributed to individual IDNs based on their share of attributed Medicaid beneficiaries.

III. IDN Application and DSRIP Project Plan Guidelines and Approval Process

a) Introduction

The IDN formation process has four key steps:

1. Potential IDNs submit an IDN Application that describes the partner organizations and their ability to serve as an IDN; identifies the Administrative Lead for the IDN; and requests Project Design and Capacity Building Funds on behalf of the IDN. The IDN Application was released for public comment on March 31, 2016 and finalized on May 6th, 2016. Completed IDN Applications are due to State on May 31st, 2016.
2. The State and its contracted Independent Assessor approve or reject IDN Applications and certify approved IDNs, which are then eligible to receive Project Design and Capacity Building Funds. This review and approval/rejection process will occur between May 31, 2016 and June 30, 2016
3. IDNs that receive Project Design and Capacity Building Funds must then develop and submit an IDN Project Plan for approval. The components of the IDN Project Plan are described in the DSRIP Planning Protocol (Attachment C) Section V. It is expected that IDN Project Plans will be due on October 15, 2016
4. The State and its contracted Independent Assessor evaluates and approves IDN Project Plans. IDNs with approved IDN Project Plans are then eligible to receive performance-based incentive payments. The state will approve IDN Project Plans as early as November 1, 2016 and no later than December 31, 2016.

The IDN Application and IDN Project Plan are both described in more detail below.

b) IDN Applications

In accordance with Section V of the STCs, the state has developed an application that IDNs must complete to be certified as an IDN, which in turn allows the IDN to receive IDN Project Design and Capacity Building Funds. The state is required to review and approve or reject IDN applications and IDN Project Design and Capacity Building Funds by June 30, 2016.

An organization interested in serving as an Administrative Lead must submit an IDN Application on behalf of itself and participating partner organizations. The IDN Application solicits information to assess whether: (a) an applicant is qualified to serve as an Administrative Lead; (b) the proposed IDN meets the composition standards outlined in Section II; and (c) the IDN is eligible to receive Project Design and Capacity Building Funds.

The state's IDN Application, reflecting input from stakeholders and the public, requires applicants to provide the following:

1. Identification of IDN Administrative Lead, and description of its financial controls/process and its qualifications/capabilities in coordinating transformation initiatives
2. Preliminary network of participating organizations and a description of existing active working relationships among organizations
    - Network information will also be used by the state to calculate preliminary member attribution and evaluate whether the proposed IDN meets minimum size/coverage thresholds
3. Description of stakeholder process to be used to solicit community input
4. High-level description of local behavioral health-specific needs
5. Description of Project Plan development process
6. Explanation of why Project Design and Capacity Building Funds are needed and how they will be used to prepare IDN Project Plans and support the transformation goals of the demonstration

Multiple IDNs may apply. It is anticipated that there will likely be one IDN in many areas of the state, but multiple IDNs may emerge in more heavily populated regions.

c) IDN Project Plans

Once IDNs have been selected though the IDN Application process, organizations participating in the IDN will collaborate to prepare an IDN Project Plan. The Project Plan will provide a blueprint of the work that an IDN intends to undertake, including which projects it has selected; explain how the work responds to community-specific needs and furthers the objectives of the demonstration; 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.

An IDN Project Plan template will be developed by the state and posted for public comment prior to finalization. Additional information on the key components of the IDN Project Plan can be found in the DSRIP Planning Protocol (Attachment C), Section V. According to a timeline to

be developed by the state and consistent with the requirements in Section V of the STCs, IDNs are required to submit final IDN Project plans to the state for review. An Independent Assessor contracted by the state will review and evaluate submitted IDN Project Plans. The state will approve applications and initiate IDN Transformation Fund payments for projects as early as November 1, 2016, but no later than December 31, 2016.

IV. Projects, Metrics, and Metric Targets

a) Overview of Projects

IDNs will design and implement six DSRIP projects, selected from the Project Menu described in the DSRIP Planning Protocol (Attachment C). IDNs must develop Project Plans based on these selected projects that are directly responsive to the needs and characteristics of the behavioral health populations that they serve and the transformation objectives furthered by this demonstration.

Projects described in the DSRIP Planning Protocol (Attachment C) are grouped into three categories: Statewide Projects, a Core Competency Project, and Community-Driven Projects. The IDN will be responsible for demonstrating progress against process milestones and outcome metrics for each project. As described in the DSRIP Planning Protocol (Attachment C), Section III, IDNs are required to implement: two Statewide Projects (Behavioral Health Work Force Capacity Development and Health Information Technology Infrastructure to Support Integration); one Core Competency Project (Integrated Healthcare); and three Community Driven Projects that reflect the particular priorities of the communities that they serve (one project from each Community Driven project sub-category). IDNs must select at least one Community Driven project focused primarily on the substance use disorder (SUD) population.

b) Project Metrics

As part of the IDN Project Plan, which is further described in Attachment C Section V, IDNs will develop timelines for implementation and completion of each project, in alignment with state-specified process milestones included in the Project Metrics and Specification Guide. As described in Attachment C Section IV and in accordance with STC 24, project performance will be measured based on metrics that track: project planning/implementation progress (Stage 1), project utilization and system transformation metrics (Stage 2 and 3), and progress towards transition to Alternative Payment Models (Stage 4).

IDNs will report on these metrics in their semi-annual reports (described in Section VI) and will receive fiscal incentive payments from the IDN Transformation Fund if they meet performance metrics targets (based on the mechanism described in Section V).

c) *Stage 2 and 3 Performance Metric Goals and Improvement Targets*

IDNs must have a performance goal for each Stage 2 or 3 performance metric. The state will measure IDN improvement from a baseline towards this goal to evaluate whether or not the IDN has achieved the metric improvement target each semi-annual reporting period. Performance goals will be based on the 85th percentile of performance within the state during the baseline period.

Each IDN will have its own baseline starting point, based on historical data that will be generated after IDN networks are finalized and it is possible to establish an IDN-specific baseline. For certain measures, including newly created measures, baseline data will be collected during 2017, at which point the performance goal and annual IDN improvement targets will be established for 2019 and 2020.

The state will set annual improvement targets for IDN metrics that reflect annual progress towards closing the relative gap by 15% between the baseline performance of each IDN and the goal for each metric. These data will be used to determine the size of the "gap to goal" for the purpose of setting annual improvement targets. This methodology is further explained through the following illustrative example:

Illustrative Example:
Metric: Potentially Preventable ER Visits for BH Population (visits/1,000)
Goal: 125.4 visits/1,000 (85th percentile of baseline IDN performance)

In this example, IDN #1 has a baseline preventable ED visit rate of 210.2 visits/1,000. The gap between 210.2 visits/1,000 and the 85th percentile goal of 125.4 visits/1,000 is 84.8 visits/1,000. The IDN's annual improvement targets will be set to require that the IDN close this 84.8 visits/1,000 gap by 15% (or 12.7 visits/1,000) each year. IDN #2, on the other hand, has a baseline performance level of 180.7 visits/1,000. Therefore, the 'gap-to-goal' for IDN #2 is 55.3 visits/1,000 (difference between 180.7 visits/1,000 and the goal of 125.4 visits/1,000). The IDN's annual improvement targets will be set to require that the IDN close this 55.3 visits/1,000 gap by 15% (or 8.3 visits/1,000) per year.

In cases where IDN performance meets or exceeds 85th percentile of performance within the state, annual improvement targets will reflect a 5% annual improvement in the metric from the

IDN's prior year baseline, up to a maximum to be determined by the NH DHHS Office of Quality Assurance and Improvement. In other words, if IDN #3 has a baseline performance level of 123.2 visits/1,000 in the example above, the IDN already exceeds the 85th percentile goal of 125.4 visits/1,000. Therefore, rather than following a 'gap-to-goal' target-setting methodology, this IDN would be required to improve performance on this metric by 5% per year, up to a maximum to be determined by the NH DHHS Office of Quality Assurance and Improvement. A 5% absolute improvement from a baseline level of 123.2 visits/1,000 would result in a target of 117.4 visits/1,000 for the first performance measurement year.

In other cases, baseline performance on a metric across IDNs may be too similar/concentrated or an IDN's baseline performance may already be too close to the 85th percentile goal to allow for meaningful improvement using a 'gap-to-goal' methodology. In these cases, the state will use a comparable national benchmark or require 5% annual improvement in the metric from prior year's baseline in establishing the performance goal.

V. Incentive Funding Formula and Year 1 Design and Capacity Building Funds

a) Year 1 Funding

i. Capacity Building and Design Fund

In accordance with STC 31, during calendar year 2016, the State will provide payments to approved IDNs from a designated IDN Project Design and Capacity Building Fund. This funding can be used by approved IDNs to develop specific and comprehensive IDN Project Plans and to begin to develop the technology, tools and human resources that will allow IDNs to build capacity and pursue demonstration goals in accordance with community-based priorities.

Payments from the IDN Project Design and Capacity Building Fund will total up to 65% of demonstration Year 1 funding from the IDN Transformation Fund. The amount of Project Design and Capacity Building Funds allocated to each IDN will be based on a calculation with two components: 1) a fixed component, calculated assuming equal distribution of 50% of total available funds evenly across all approved IDNs and 2) a variable component that is calculated by assuming the remaining 50% of total funds is distributed proportionately among IDNs based on their share of attributed Medicaid beneficiaries.

As described in Section III, IDN Applications will require each applicant to describe in detail its qualifications, network composition, why Project Design and Capacity Building funds are being requested and how they will be used to prepare IDN Project Plans and support the transformation

goals of the demonstration. Potential IDNs must meet specific minimum qualifications, size thresholds and network coverage thresholds in order to be considered for approval. In addition, IDN applications will be scored on a relative basis by the State's contracted Independent Assessor. Only those IDNs selected through this evaluation process will be approved. Approved IDNs will receive Project Design and Capacity Building funds, which will be used to develop specific and comprehensive IDN Project Plans and to begin to develop the technology, tools, and human resources that will allow IDNs to build capacity and pursue demonstration goals in accordance with community-based priorities. In order to be eligible for any payments beyond Project Design and Capacity Building funds, an approved IDN will need to submit and receive state approval for an IDN Project Plan.

ii. Project Funding

The state will award the remaining 35% of Year 1 funding available for incentive payments from the IDN Transformation Fund (excluding state administrative expenses) to approved IDNs upon successful submission and state approval of an IDN Project Plan. Year 1 incentive payments will be allocated to IDNs based on each IDN's share of total attributed Medicaid beneficiaries.

b) Year 2-5 IDN Incentive Funding and Project Valuation

For years 2 through 5 of the demonstration, IDNs will continue to earn performance-based incentive funding by achieving defined targets for individual process and outcome metrics. During Year 1 of the demonstration, the state will determine the maximum amount of performance-based incentive funding available to be earned by each IDN annually for Years 2-5 of the demonstration. This annual amount will be driven by the size of the IDN's attributed population (described in Section II) and be allocated across three project groups in proportion to the relative intensity of effort and benefit of each project group over the life of the 5-year demonstration. Each project will have associated process and outcome metrics that must be achieved for IDNs to earn funding associated with a project group in a given year.

The maximum amount of incentive funding for each IDN will be calculated based on the methodology described in (i) below. Once the overall maximum valuation is determined, the value for the individual metrics of the IDN Project Plan is determined based on the distribution method described in (ii) below. Project values are subject to monitoring by the state and CMS, and IDNs may receive less than their maximum available project valuation if they do not meet their designated metrics and/or if statewide DSRIP funding is reduced because of the statewide penalty (described in Section VIII(a) below).

i. Calculating Maximum IDN Project Valuation

Step 1: Assigning Project Group Weighting

Each IDN will be required to implement six projects from the Project Protocols Menu of the DSRIP Planning Protocol (Attachment C, Section III). Of these six projects, two will be the mandatory Statewide projects, one will be the mandatory Core Competency project, and three will be selected by the IDN from the menu of Community Driven projects (one from each Community Driven project sub-category).

As required in Section V of the STCs, the value of funding for each IDN project will be proportionate to its potential benefit to the health and health care of Medicaid beneficiaries. Since many projects within a project group are co-dependent and share similar metrics, the value of individual projects within a project group will be identical.

Each of the three project groups (Statewide, Core Competency, Community-Driven) is assigned a relative weighting as a percentage of total project funding available to be earned in a given DSRIP Year. The state will assign weightings at the project *group* level, based on value of the program outcomes to the demonstration goals and intensity of resources required to implement the projects within that group. Project groups will be valued relative to one another, as a percentage of the total project funding available within a given year. The percentage allocation to each project group will vary over time to reflect the relative intensity of effort and benefit of each project group over the life of the 5-year demonstration. Therefore, for example, meeting milestones and metrics associated with the two Statewide Projects will account for 50% of funding IDNs can earn in DSRIP Year 2, and 20% of funding in DSRIP Year 5. The table below provides the relative percentage weighting by project group by year.

Table 3: Year 2-5 Incentive Funding Allocation by Project Group

Project Group	Year 2 (2017)	Year 3 (2018)	Year 4 (2019)	Year 5 (2020)
Statewide Projects	50%	50%	30%	20%
Core Competency Project	30%	30%	50%	60%
Community-Driven Projects	20%	20%	20%	20%

Step 2: Calculating Maximum IDN Project Funding

The maximum IDN incentive funding for each year for each project group is calculated by multiplying the total available statewide IDN incentive funding for that year by the weighting percentage of that project group and the proportion of total Medicaid beneficiaries attributed to the IDN (based on the attribution method described in Section II above), as shown below:

Maximum IDN Project Funding by Year for Each Project Group = [*Total Statewide IDN Transformation Funds available*] x [*Project Group Weight*] x [*% of Total Attributed Medicaid Beneficiaries*]

This same formula will be repeated for all project groups, and the sum of all three project group funding will equal the total maximum amount of financial incentive payments ("maximum IDN project funding") that the IDN could potentially earn based on performance.

Maximum IDN Project Funding by Year for an IDN = [*Maximum IDN Funding for Statewide Project Group*] + [*Maximum IDN Funding for Core Competency Project Group*] + [*Maximum IDN Funding for Community-Driven Project Group*]

The maximum IDN project funding represents the highest possible financial allocation that each IDN can receive for its menu of projects over the duration of its participation in the demonstration. IDNs may receive less than their individualized maximum allocation if they do not meet metrics and/ or if demonstration funding is reduced because of the statewide penalty (described in Section VIII below).

ii. Earning Incentive Payments

As described above, Year 1 incentive funding from the IDN Transformation Fund will be awarded to approved IDNs upon successful submission and state approval of an IDN Project Plan. In years 2 through 5, each IDN will be able to receive incentive payments up to its Maximum IDN Project Funding amount by meeting or exceeding its designated performance metrics. Each project will have specific process metrics and/or performance metrics, as specified in the Project and Metrics Specification Guide.

As described in STC 24 and further detailed in Section IV of the DSRIP Planning Protocol (Attachment C), performance metrics and milestones will be organized into the following stages:

i) Stage 1: Project planning and progress milestones
ii) Stage 2: Project utilization milestones
iii) Stage 3: System transformation utilization milestones
iv) Stage 4: Alternative Payment Model milestones

As described in Section IV, Stage 1 process milestones for each project are detailed in the Project and Metrics Specification Guide. For Stage 2 and 3 measures, the state will measure baseline performance and identify annual improvement targets based on identified goals. Stage 4 milestones are also established by the state and are described further in Attachment C.

Within each reporting period, IDNs will be scored on their performance towards achieving their designated metric targets. Scores for an IDN will be expressed as "meeting" or "not meeting" the process milestone and/or outcome improvement target. The point value given for reaching a specified performance target/metric will be called an Achievement Value (AV) and will be assigned either a 0 or 1. If an IDN meets a process milestone or outcome metric, it will receive an AV of 1 for that process metric/outcome metric in that reporting period. If the IDN does not meet its metric or performance target, it will receive an AV of 0 for that metric for that reporting period.

The AV for each metric will be summed to determine the Total Achievement Value (TAV) for the project group during any given reporting period. A Percentage Achievement Value (PAV) will then be calculated by dividing the TAV by the maximum available AV (the total number of metrics/metrics) for the reporting period in each project group. The PAV will reflect the percentage of metrics achieved by an IDN for each project group for a given reporting period, and be used to calculate how much of the project group's maximum available funding was earned by the IDN.

Example: An IDN is able to earn a maximum of $1,000,000 in the second payment period in Year 3 for Community-Driven Projects. If the IDN achieves four out of ten of the required milestones/metrics for Community-Driven Projects, the IDN would receive 40 percent of the $1,000,000 or $400,000.

In accordance with STC 27g, the state will shift funding over the duration of the demonstration, from a focus on rewarding achievement of process (Stage 1) milestones in the early years of the demonstration, to rewarding improvement on Stage 2, 3, and 4 performance metrics in the later years of the demonstration. This timing of accountability for IDN performance will be based on the following overall distribution pattern:

Table 4: Percent of funding contingent on IDN performance, by milestone/metric type

Milestone/Metric Type	Year 2 (2017)	Year 3 (2018)	Year 4 (2019)	Year 5 (2020)
Stage 1 Process Metrics/Milestones	90%	75%	0%	0%
Stage 2, 3, 4 Performance Metrics/Milestones	10%	25%	100%	100%

When combined with the allocation of incentive funding by project group (see Table 3), the allocation of incentive funding by project group and milestone/metric type is as follows:

Table 5: Percent of funding contingent on IDN performance, by project group and milestone/metric type

	Year 2 (2017)		Year 3 (2018)		Year 4 (2019)		Year 5 (2020)	
Project Group								
Statewide Projects	50%		50%		30%		20%	
Core Competency Project	30%		30%		50%		60%	
Community-Driven Projects	20%		20%		20%		20%	
Milestone/Metric Type	**Stage 1**	**Stage 2,3,4**	**Stage 1**	**Stage 2,3,4**	**Stage 1**	**Stage 2,3,4**	**Stage 1**	**Stage 2,3,4**
	90%	10%	75%	25%	0%	100%	0%	100%
Resulting Allocation by Milestone/Metric Type and Project Group	**Stage 1**	**Stage 2,3,4**	**Stage 1**	**Stage 2,3,4**	**Stage 1**	**Stage 2,3,4**	**Stage 1**	**Stage 2,3,4**
Statewide Projects	45%	5%	37.5%	12.5%	0%	30%	0%	20%
Core Competency Project	27%	3%	22.5%	7.5%	0%	50%	0%	60%
Community-Driven Projects	18%	2%	15%	5%	0%	20%	0%	20%
All Projects	*90%*	*10%*	*75%*	*25%*	*0%*	*100%*	*0%*	*100%*

iii. Maximum IDN Project Funding and Incentive Payments: Illustrative IDN Example

The example in Table 6 below illustrates how the funding allocations in Table 5 will drive the maximum amount of funding available for different categories of incentive payments at a statewide and an illustrative IDN level. The example is based on the following assumptions:

- Illustrative total funding available for distribution to IDNs over the course of the 5-year demonstration: $142 million ($28.4 million per year). The final funding amount available for distribution will depend on the precise level of funding required for the state to

administer and support the implementation the program, including statewide planning efforts.

- Assumed number of total IDNs: 7 (illustrative). Actual number will be finalized through the IDN Application process.
- Example IDN percent of total statewide attributed Medicaid beneficiaries: 12.5%. Actual attribution will be calculated based on the final network composition of each approved IDN.
- Percent of Year 1 available dollars allocated to Project Design and Capacity Building Fund: 65% (remaining 35% of Year 1 available dollars available for distribution to approved IDNs upon successful submission and state approval of an IDN Project Plan). This reflects the maximum allocation of Project Design and Capacity Building Funds and is subject to change based on the precise level of funding required for the state to administer and support the implementation the program, including statewide planning efforts.

Under this example, in Year 3 of the demonstration (2018), of the $28,400,000 total available for distribution to IDNs in incentive payments, $11,360,000 (or 40%) is available to be earned through IDN achievement the milestones and performance metric targets associated with the Statewide Projects.

The illustrative IDN in this example can earn a maximum of $3,550,000 each year from 2017-2020 through the achievement of milestones and performance metric targets. In 2017, for example, the IDN can earn a maximum of $958,500 through the achievement of Stage 1 milestones associated with the Core Competency Project, and $106,500 for the achievement of Stage 2,3,4 performance targets associated with that project.

Table 6: Illustrative Funding Mechanics Example (Statewide and IDN-level)

	Year 1 (2016)	Year 2 (2017)	Year 3 (2018)	Year 4 (2019)	Year 5 (2020)
Illustrative Maximum Statewide Funding Totals					
Maximum Funding Available for Distribution by Year: *Statewide Total (Illustrative)*					
Funding Available	$28,400,000	$28,400,000	$28,400,000	$28,400,000	$28,400,000
Maximum Year 1 Funding: *Statewide Total (Illustrative)*					
Y1 Design/Capacity Funds	$18,460,000	N/A	N/A	N/A	N/A
Y1 Remaining Payments	$9,940,000	N/A	N/A	N/A	N/A
Total	*$28,400,000*				
Maximum Year 2-Year 5 Funding by Project Group: *Statewide Total (Illustrative)*					
Project Group					
Statewide Projects	N/A	$14,200,000	$14,200,000	$8,520,000	$5,680,000
Core Competency Project	N/A	$8,520,000	$8,520,000	$14,200,000	$17,040,000
Community-Driven Projects	N/A	$5,680,000	$5,680,000	$5,680,000	$5,680,000
Total		*$28,400,000*	*$28,400,000*	*$28,400,000*	*$28,400,000*
Illustrative Example IDN Maximum Funding					
Maximum Funding Available to be Earned by *Example IDN*, by Milestone/Metric Type and Project Group *(Illustrative)*					

	Year 1 Max Payments [1]	Stage 1	Stage 2,3,4	Stage 1	Stage 2,3,4	Stage 1	Stage 2,3,4	Stage 1	Stage 2,3,4
Y1 Design/Capacity Funds	$2,472, 321								
Y1 Remaining Payment	$1,242,500								
Statewide Projects	N/A	$1,597,500	$177,500	$1,331,250	$443,750	$0	$1,065,000	$0	$710,000
Core Competency Project	N/A	$958,500	$106,500	$798,750	$266,250	$0	$1,775,000	$0	$2,130,000
Community-Driven Projects	N/A	$639,000	$71,000	$532,500	$177,500	$0	$710,000	$0	$710,000
Total	*$3,714,821*	*$3,550,000*		*$3,550,000*		*$3,550,000*		*$3,550,000*	

[1] As described in Section IV, the amount of Project Design and Capacity Building Funds allocated to each IDN will be based on a calculation with two components: 1) a fixed component, calculated assuming equal distribution of 50% of total available funds evenly across all approved IDNs and 2) a variable component that is calculated by assuming the remaining 50% of total funds is distributed proportionately among IDNs based on their share of attributed Medicaid beneficiaries. The state will award the remaining 35% of Year 1 funding available for incentive payments from the IDN Transformation Fund (excluding state administrative expenses) to approved IDNs upon successful submission and state approval of an IDN Project Plan. Year 1 incentive payments will be allocated to IDNs based on each IDN's share of total attributed Medicaid beneficiaries.

VI. IDN Reporting Requirements

These activities are detailed below.

a) Semi-Annual Reporting for IDN Project Achievement

Two times per year, IDNs seeking payment under the demonstration shall submit reports to the State using a standardized reporting form approved by the State and CMS. IDNs will use the document to report on their progress against the milestones and metrics described in their approved IDN Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with Section V and Section VIII. The IDNs reports will be reviewed by the State and may be reviewed by CMS. Upon request, IDNs will provide back-up documentation and data in support of their progress. These reports will be due as indicated below after the end of each reporting period:

- For the reporting period encompassing January 1 through June 30 of each year: the semi-annual report and the corresponding request for payment must be submitted by an IDN to the State before July 31.
- For the reporting period encompassing July 1 through December 31 of each year: the semi-annual report and the corresponding request for payment must be submitted by an IDN to the State before January 31.

The state shall have 30 business days after these reporting deadlines to review and approve or request additional information regarding the data reported for each milestone/metric and measure. If additional information is requested, the IDN shall respond to the request within 15 business days and the State shall have an additional 15 business days to review, approve, or deny the request for payment, based on the additional information provided. The state shall schedule the payment transaction for each IDN within 30 business days following state approval of the IDN's semi-annual report.

VII. State Oversight Activities

The state will provide various types of oversight to ensure accountability for the demonstration funds being invested in New Hampshire, as well as to promote learning within New Hampshire and across the country from the work that is being done under the demonstration. Throughout the demonstration, the State, and/or its designee, will oversee and monitor the activities of IDNs and submit regular reports to CMS.

Certified IDNs must enter into a contract with the New Hampshire DHHS to be eligible to receive Project Design and Capacity Building Funds, as well as other incentive funding under the demonstration. This contract will set forth the requirements and obligations of the IDN Administrative Lead and other participating organizations in the IDN, including reporting requirements, data sharing agreements, performance standards, compliance with the Standard Terms and Conditions of the waiver, and agreement to participate in state oversight and audit activity to ensure program integrity of the demonstration. In the contract, the State will require IDNs to participate in the semi-annual IDN reporting process outlined above as a condition of qualifying for demonstration funds.

In addition, New Hampshire is dedicating staff to the demonstration who will be charged with providing day-to-day monitoring and oversight of IDN activities, including:

- The speed and scale of progress made by each IDN towards meeting its milestones
- The specific activities that are driving measureable change
- The key implementation challenges, including governance issues, associated with specific activities designed to drive improvement, and effective strategies for addressing them
- The need for any adjustments to the demonstration to maximize its effectiveness

The State also will support IDN implementation by sponsoring an IDN Learning Collaborative and providing guidance and support on the state's expectations and requirements. Four of the state activities and reports designed to ensure program integrity and transparency, promote cross-IDN learning, and conduct evaluation are described in more detail below:

i. Quarterly Operational Reports

In accordance with STC 41 and as outlined in Attachment A, the state will submit progress reports on a quarterly basis to CMS. The reports will present the state's analysis of the status of implementation; identify challenges and effective strategies for overcoming them; review available data on progress toward meeting metrics; and describe upcoming activities. This report will also include an Executive Summary which can be used by CMS, senior state officials and the public as a means of tracking the overall progress of the demonstration.

ii. Learning Collaborative

A Learning Collaborative will be sponsored by the State to support an environment of learning and sharing among IDNs through in-person and virtual meetings. Specifically, the LC will promote the exchange of strategies for effectively implementing projects and addressing

operational, administrative and data challenges. The state also will use the LC to provide statewide updates on the demonstration, disseminate best practices, and gather feedback on where additional clarification of state expectations and requirements are needed. Depending on the number and type of projects chosen by IDNs, there may be multiple strains of the Learning Collaborative that allows similarly-situated IDNs to work together on specific challenges or projects.

iii. Web Site and Reporting Tool

The state will develop and regularly update a web site that provides information on the demonstration to participating IDNs, policymakers and members of the public. It will offer access to a centralized tool or system that tracks and disseminates information on the demonstration, participating IDNs, and projects. A key component of the tool will be a reporting feature that conveys key information on the status of demonstration progress for various audiences including that of the general public and CMS. The tool will deliver data that can 1) be easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

iv. Program Evaluation

As described in STCs 72 and 78 in Section X, the state will contract with an independent evaluator to evaluate the demonstration. The evaluator will be selected after a formal bidding process that will include consideration of the applicants' the qualifications, experience, neutrality, and proposed budget. The evaluation will be completed by June 30, 2021.

VIII. Statewide Performance and Unearned IDN Funding

a) *Accountability for State Performance*

As described in STC 35 in section V, the state will be accountable for demonstrating progress towards meeting the demonstration's objectives of building greater behavioral health capacity; better integrating physical and behavioral health; and improving care transitions. Funding for IDNs may be reduced in demonstration Years 3, 4, and 5 if the State fails to demonstrate progress on the four statewide metrics described below. Based on statewide performance on these four measures, available IDN Transformation Funds may be reduced by the amount specified in STC 35 in Section V. The funding reductions will be applied proportionately to all IDNs based on their maximum IDN Project Funding amount.

A state-wide performance goal will be established for each of the following four metrics. The state will be accountable for achieving these goals by the end of the demonstration period, DSRIP Year 5. During DSRIP Years 3, 4, and 5, annual improvement from a baseline towards these goals will be used to evaluate whether or not the state-wide metric improvement target has been achieved.

Statewide Accountability Metrics

i. Readmission to Hospital for Any Cause (Excluding Maternity, Cancer, Rehab) at 30 days for Adult 18+ Behavioral Health Population
ii. Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers
iii. Potentially Preventable ER Visits for BH Population and Total Population
iv. Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)

The state will establish baseline performance for each measure. The statewide goal to be achieved by the end of the demonstration period will be based on the 75th percentile of IDN performance levels during the baseline period. For metric ii (use of standardized core assessment framework), the state will be accountable for demonstrating a statewide rate of 75% by the end of the demonstration period.

Annual improvement targets will reflect closing of the relative gap between the baseline and the goal by 15% each year. For example, if the gap between the baseline and the 5-year goal is 75 visits/1,000, the state will be accountable for closing that gap by 15% of 75 visits (11.3 visits/1,000) each year.

The levels of potential statewide funding at risk each year is outlined in STC 35, section V. This funding will be divided equally among the four statewide accountability metrics. If the state fails to achieve its annual improvement target on a given statewide accountability metric, funding will be reduced by the amount tied to that measure (i.e, 25% of total funding at risk for statewide performance).

b) *Unearned IDN Funding and the DSRIP Performance Pool*

IDNs will be permitted to "reclaim" incentive funding that is unearned because the IDN failed to achieve certain performance metrics for a given reporting period. Funding amounts that are unearned will be available to the IDN for two immediate, subsequent reporting periods, with the exception of DY 5. To "reclaim" the unearned incentive funds, an IDN must not only demonstrate that it has achieved the original process or outcome metric target, but that it has also achieved its most recent target for the same metric. If an IDN is not able to reclaim the

unearned incentive funding in the two immediate, subsequent reporting periods, the funds will be forfeited by the IDN and placed into a general DSRIP Performance Pool. The DSRIP Performance Pool will be used to the support the scope of the statewide DSRIP program or to reward IDNs whose performance substantively and consistently exceeds their targets. The State does not plan to withhold any amounts to subsidize this Performance Pool.

IX. Demonstration Mid-Point Assessment

A mid-point assessment will be conducted in demonstration Year 3. Based on qualitative and quantitative research and stakeholder and community input, the midpoint assessment will be used to systematically identify recommendations for improving individual IDNs and implementation of their Project Plans; state policies and procedures for oversight; and any other elements of the demonstration that may be hampering the effective and efficient use of funds and progress toward the demonstration's goals. IDNs will be required to participate in the mid-point assessment, and to adopt IDN-specific recommendations that emerge from the review. The state may withhold future IDN Transformation Fund incentive payments to an IDN if it fails to adopt recommended changes even if all other requirements for DSRIP payment are met. If the review identifies recommendations for change to the STCs (including attached protocols), the state will submit an amendment request, in accordance with STC 7, to CMS for changes on or before October 1, 2018.