Project Title	*B1: Integrated Healthcare*
Project ID	**B1**
Project Pathway	Core Competency
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 workflows, joint service protocols and communication channels with community based social support service providers
- Coordination with other care coordination/management programs or resources that may be following the same patient is critical. To the extent possible, only one care coordinator/manager is playing a lead role in managing
- the patient's care plan
- Adherence to New Hampshire Board of Medicine guidelines on opioid prescribing

Information Sharing: Care Plans, Treatment Plans, Case Conferences

- Information is regularly shared among team members using:
    - Documented workflow that ensures timely communication of a defined set of clinical and other information critical to diagnosis, treatment, and management of care. It is expected that communication be enabled via electronic means

	(e.g., shared EHR or coordinated care management system) or that providers are advancing along a continuum towards electronic communication. ○ On behalf of patients with significant behavioral health conditions or chronic conditions, regularly scheduled (minimum monthly) core team (plus other providers as needed) case conferences. ○ Documented workflows that incorporate a communication plan inclusive of protocols related to what information is provided to treatment providers, what is available to community-based organizations and how privacy will be protected. Closed-loop referral capabilities (electronic or non-electronic). *Standardized workflows and protocols* • Written roles, responsibilities, and workflows for core team members • Protocols to ensure safe care transitions from institutional settings back to primary care, behavioral health, and social support service providers. • Intake procedures that include systematically solicit patient consent to confidentially share information among providers **Additional Integrated Practice designation requirements:** • All of the requirements for the Coordinated Care Practice designation above • Adoption of both of the following evidence-based interventions: 1. Medication-assisted treatment (MAT) 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 workflows, joint service protocols and communication channels with community based social support service providers, including closed-loop referral capabilities. (See also the Statewide Health Information Technology project A2) Additional information and support can be found at: http://www.integration.samhsa.gov/about-us/pbhci http://impact-uw.org/
Process Milestones	As part of the 2017-2018 semi-annual IDN reporting process, IDNS are required to demonstrate that organizations participating in this

project have achieved the following process milestones during, or in advance of, the timeframe noted. *All* primary care and behavioral health practices within an IDN are expected to meet '*Coordinated Care Practice'* designation. As part of its Project Plan, IDNs will identify practices within the IDN that will meet the additional requirements necessary for *Integrated Care Practice* designation.

Jan-Jun 2017 Reporting Period

Development of implementation plan, which includes:

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

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

a. Comprehensive Core Standardized Assessment and screening tools applicable to adults, adolescents, and children
b. Shared Care Plan for treatment and follow-up of both behavioral and physical health to appropriate medical, behavioral health, community, and social services.
c. Protocols for patient assessment, treatment, management
d. Referral protocols including to those to/from PCPs, BH providers, social service support providers, Hospitals, and EDs
e. Core team meeting/communication plan and relevant workflows for communication among core care team and other patient providers, including case conferences
f. Written roles and responsibilities for core team members and other members as needed,
g. Training plan for each member of the core team and extended team as needed
h. Training curricula for each member of the core team and extended team as needed
i. Agreements with collaborating providers and organizations including:
    i. Referral protocols

ii. Formal arrangements (Contract or MOU) with community based social support service providers
iii. Coverage schedules
iv. Consultant report turnaround time as appropriate

j. Evaluation plan, including metrics that will be used as ongoing impact indicators to provide the IDN with sense of whether they are on the path to improve broader outcome measures that drive payment
k. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to integration framework (e.g., using the *Maine Site Self-Assessment Evaluation Tool for the Main Health Access Foundation Integration Initiative*)

Jul-Dec 2017 Reporting Period

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

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

a. Implementation of workforce plan (staffing plan; recruitment and retention strategies)
b. Deployment of training plan
c. Use of annual Comprehensive Core Standardized Assessment
d. Use of Shared Care Plan
e. Operationalization of Core Team meeting/communication plan, including case conferences
f. Use of shared EHR, electronic coordinated care management system, or other documented workflow 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

	<u>Jan-Jun 2018 Reporting Period</u> **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 **<u>Jul-Dec 2018 Reporting Period</u>** **By December 31, 2018, all practices identified for *Integrated Care Practice* designations must have achieved the additional requirements described in the Core Project Components above.** **Ongoing data reporting** a. Number of Medicaid beneficiaries receiving annual Comprehensive Core Standardized Assessment (during reporting period and cumulative), vs. projected b. Number of Medicaid beneficiaries scoring positive on screening tools c. Number of Medicaid beneficiaries scoring positive on screening tools and referred for additional intervention d. Number of new positions recruited and trained (during reporting period and cumulative), vs. projected e. New staff position vacancy and turnover rate for period and cumulative vs projected f. Impact indicator measures as defined in evaluation plan, including annual evaluation of fidelity to evidence- supported program elements