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]
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

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

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*

#	PROJECT	DESCRIPTION
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

#	PROJECT	DESCRIPTION
		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 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.

#	PROJECT	DESCRIPTION
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.
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.

#	PROJECT	DESCRIPTION
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. <u>Process Milestones</u> (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. Outcome Metrics (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	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	
					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 Encounter Data	Number who had first psychiatrist visit within 30	Population new to CMHC system per Phoenix data who had intake	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?[2]	Active Year(s)[3]				Associated Projects
								2017	2018	2019	2020	
			Reporting System	days of intake appointment	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.
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.

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
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.
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.

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
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 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.

Focus	Intervention	Sub-intervention	Condition	Sub-condition	Target Population	Measure Definition
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.