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**Call for Applications:**

**Implementation and Evaluation of an Integrated Behavioral Health (IBH)**

**Model in Primary Care**

**Care Transformation Collaborative of Rhode Island (CTC-RI) is pleased to offer CTC primary care practices the opportunity to apply for funding for the Integrated Behavioral Health Pilot Program. Outlined below is the IBH “Call for Applications” from Care Transformation Collaborative (CTC) for primary care practices.**

**CTC VISION**

Rhode Islanders enjoy excellent health and quality of life. They are engaged in an affordable, integrated healthcare system that promotes active participation, wellness, and delivers high quality comprehensive health care.

**CTC MISSION**

To lead the transformation of primary care in Rhode Island in the context of an integrated health care system; and to improve the quality of care, the patient experience of care, the affordability of care, and the health of the populations we serve.

**CTC STRATEGIC GOAL**

To develop, implement and evaluate a sustainable IBH model serving adult patients within primary care settings.

**CTC COMMITTEE OVERSIGHT**

The IBH Committee, which includes medical and behavioral health providers, health plans, state agencies and key stakeholders, developed the clinical and financial IBH business model that will be tested through this IBH pilot program.

An evaluation plan is incorporated into the pilot program which will determine the effectiveness of the integrated clinical model in the primary care setting. The evaluation plan that is integrated into this pilot study will help determine cost savings from emergency department /inpatient usage and how those savings could be incorporated to sustain future IBH efforts in the primary care setting.

Both the IBH Committee and the CTC Data and Evaluation Committee will provide oversight for the pilot project with periodic reports presented to the CTC Board of Directors.

The IBH Committee, together with CTC Management, developed an IBH Sustainable Business Model with the goal of:

* Testing of payment models that integrate and align incentives to address public health, social services and behavioral health; and
* Developing payment systems towards a value-based model.

**CTC Sustainable IBH Business Objectives:**

* To increase the identification of patients with behavioral health and substance use disorders (SUD) through universal screening for depression, anxiety and SUD;
* To increase ready access to brief behavioral health intervention for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions;
* To provide care coordination and intervention for patients with high emergency department (ED) utilization;
* To improve interdisciplinary care coordination for patients with severe mental illness and SUD; and
* To test the proposed financial model for long term sustainability with particular attention to ED and in-patient (IP) utilization/total cost of care as sustainable measures.

**CTC IBH Details:**

CTC seeks to establish a pilot that provides IBH services to a total of 30,000 attributed patient lives (or patient panel of 48,000 lives) through an anticipated staffing plan of 48 medical providers and 6 behavioral health clinicians (1 FTE behavioral health provider per 5,000 attributed lives) over a three year time period.

There will be two IBH program cohorts (each with eight (8) practices or serving a combined attributed patient population of 15,000 attributed patients per cohort) that will be eligible for two years of funding to support IBH efforts.

Cohort 1: January 1, 2016 to December 2017 (with expectation that data will be collected through 10/31/18);

Cohort 2: November 1, 2016 to October 31, 2018 (with some training pre-work required based on practice readiness).

Each cohort will have a phased Start-Up Year 1 and a second Performance Year (Year 2) implementation schedule with each year having defined program expectations. Funding in Start-Up Year 1 is designed to support IBH infrastructure development with incentive payment based on meeting target thresholds, and funding in Performance Year (Year 2) designed to provide incentive payment based on achieving a higher level of threshold performance.

CTC Practices in Start-Up, Transition, Performance Year 1, Performance Year 2 or Advanced Collaborative status are eligible to apply for this funding opportunity provided the practice has achieved National Committee for Quality Assurance (NCQA) PCMH Level 2 recognition.

**Benefits to the Selected Practices:**

Selected practices will receive infrastructure support during Start-Up Year 1 ($15,000 for each patient panel of 5,000 attributed lives) to support efforts to start up an IBH practice and meet the deliverable that are outlined in the pilot program (i.e. hiring process, staff training, implementation of evidence based screening tools, practice reporting, support of IBH staffing model). Practices with panel sizes less than 5,000 attributed lives are potentially eligible to apply by partnering with other practice(s) ; Such practices would be expected to apply as one application with an articulated Memorandum of Understanding that outlines how the practices would work together to meet the pilot objectives, share resources and financial support. If a practice with less than 5000 attributed lives but more than 2500 attributed lives applies and is chosen as a site, the funding will be prorated.

Practices sites will be eligible for incentive payments based on meeting screening thresholds for depression, anxiety and substance disorder use in both Start-Up (Year 1) and Performance Year (Year 2). Incentive payments will be prorated if a practice has less than 5000 attributed lives.

Incentive payment ($10,000.00 in Start-Up Year and Performance Year) for meeting thresholds for all three measures as outlined below:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Depression** | **Anxiety** | **SUD** |
| **Start-Up (Year 1)** | 70% | 50% | 50% |
| **Performance Year (Year 2)** | 90% | 70% | 70% |

Selected practices would have access to and participate in on-site IBH consultation and webinar training to assist them with implementing an IBH program geared towards providing holistic patient centered primary care services.

Primary care patients and practices would benefit from having ready access to on-site behavioral health services and a coordinated referral system to specialty behavioral health services when patient severity requires higher levels of care and coordination.

Rhode Island health plans have committed to assisting with the evaluation plan and based on evaluation results, help to determine a sustainable business model for the provision of IBH in the primary care setting. Practices that assist with testing the IBH business model will contribute to creating a sustainable primary care program that provides patients with ready access to behavioral health care.

**Assumptions:**

* Primary care practices, through the IBH model, will be able to provide on-site treatment for twenty to thirty percent of the patient population that is seen each year in the PCP setting;
* Primary care practices would utilize behavioral health compacts for no more than 20% of patients that have moderate to high screening scores for depression, anxiety and/or SUDs; and
* Primary care practices will pre-schedule monthly on-site IBH consultation; with change in circumstances, practices would be expected to re-schedule monthly meetings in order to maintain focus on meeting program objectives within the same month.

**Practice Requirements:**

**IBH Start-Up (Year 1):**

All Phase 1 requirements will be implemented within a 6-12 month timeframe.

* Provide baseline report on screening for depression, anxiety, and substance use within one (1) month of award notification;
* Hire behavioral health (BH) staff if not already in place with a staffing ratio of 1 FTE for every 5,000 attributed lives with staff ready to see patients within two (2) months of award notification;
* Provide work space for the BH clinician within the primary care setting within two (2) months of award notification;
* Implement a staffing plan for patients to be able to access BH assessment/treatment with same day to 72 hour access (within one (1) month of start date of IBH clinician or award notification if IBH clinician already hired);
* Establish billing systems that will allow for the billing of BH services and/or establish supervision of BH interns (within three (3) months of start date of IBH clinician or award notification if IBH clinician already hired);
* Implement program identified evidence based screening tools for depression, anxiety, and SUD within three (3) months of award notification; practices may request option with of using screening tools different from the PHQ-9 (depression), GAD (anxiety), or CAGE-AID (alcohol and drugs) with justification that would require approval from CTC management;
* Produce monthly practice registry reports on screening results (initial and follow-up)within four (4) months of award notification; patients with moderate to high screening scores would be re-screened within six (6) months;
* Produce quarterly reports on screening results within four (4) months of award notification;
* Commit to and host monthly on-site IBH consultation with membership to include practice leadership, physician/clinical champion, nurse care manage, practices (within 30 days of award notification);
* Commit to and participate in quarterly participation in quarterly webinar learning events;
* Commit to and establish IBH workflows including weekly review of high risk patients with BH conditions and monthly review of patients who have BH issues that interfere with management of chronic conditions with practice team (within four (4) months of award notification);
* Establish a BH compact including coordination and coordination tracking expectations to meet the needs of patients with severe depression, anxiety and SUD within three (3) months of award notification;
* Complete [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) and achieve a score of five (5) or greater prior to advancing to Performance Year 1 (Year 2);
* Assist with meeting the evaluation plan requirements which will require (but not be limited to) producing practice reports on screening and re-screening patient (based on score) and BH visit information; and
* Work to achieve screening targets by twelve (12) months.

**IBH Performance Year (Year 2) requirements:**

* Continue to perform Start-Up components;
* Monitor/ improve patients’ treatment response through care coordination review of patient registry scores for depression, anxiety and substance use, chronic care quality measures with submission of a PDSA plan to test change for improvement;
* Implement population health review for patients with high ED usage and BH needs and implement IBH strategies including submission of a PDSA to test change for improvement; and
* Achieve Screening targets to be eligible for incentive payment.

**Note:** Practices in Cohort 1 will be expected to continue to report screening results in Year 3; Practices in Cohort 2 will be expected to participate in quarterly readiness trainings to help prepare them for meeting Start-Up requirements based on [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) scores.

**Prerequisites:**

* CTC practice in Start-Up, Transition, PY1, PY 2, Advanced Collaborative Status must have current NCQA Level 2 recognition and continued achievement of CTC program requirements based on stage in developmental contract;
* Team completion and submission of [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) with application;
* Electronic health record (EHR) system that can produce registry reports based on PHQ-9, GAD, CAGE-AID screening and re-screening results with sample report or screen shot that demonstrates capacity with application;
* EHR system that can support a shared BH documentation, care plan and billing; and

A patient panel of 5,000 patients or an MOU with other practices that articulates how the practices would work together to meet the pilot objectives, share resources and financial support.

**Timeline for Selection Process:**

|  |  |  |
| --- | --- | --- |
| **Step** | **Activity** | **Date** |
| 1 | Conference call with interested parties to answer any questions. \*  Call-in number: 508-856-8222 code: 4614 | Monday 10/26/15 12pm-1pm |
| 2 | Submit letter of intent to apply electronically to:  [CTCRI@umassmed.edu](mailto:CTCRI@umassmed.edu) | Friday 10/30/15 by 5pm |
| **3** | **Practices submit completed application package- electronically to: CTCRI@umassmed.edu**  **Please include application checklist.** | **Monday 11/16/15 by 5pm** |
| 4 | A Selection Committee, which will be devised of members from the current IBH Committee, will meet to review submitted applications. | 12/1/15-12/17/15 |
| 5 | Final recommendations to CTC Board of Directors | Friday 12/18/15 |
| 6 | Notification will be sent to practices that have been chosen | Monday 12/21/15 |
| 7 | Orientation for newly selected practices | Tuesday 1/12/16 from 5pm-6:30pm |

*\*Due to space limitations, please plan to call in to one of the calls to save seats for everyone. Following the calls, a FAQ document will be posted on the website (*[*www.pcmhri.org*](http://www.pcmhri.org)*) that will include responses to questions from both calls.*

**For questions contact:**

Michele Brown, Project Coordinator

([Michele.Brown@umassmed.edu](mailto:Michele.Brown@umassmed.edu))

T: 508 421 5919 F: 508 856 6650

**Application Package Submission Checklist**

**IBH application: practices submit application by 11/16/15;**

|  |  |
| --- | --- |
| **Check if complete** | **Item** |
|  | Submit letter of intent to apply electronically to:  [**CTCRI@umassmed.edu**](mailto:CTCRI@umassmed.edu)  Letter to include: practice name, practice address, physician champion, practice leadership person, application key contact name of person responsible for project implementation, email address, and phone. If a multi-site practice, indicate physician champion at each site. |
| Final Package for Submission | |
|  | Cover letter indicating the practice’s commitment and acceptance of the conditions stated in the application, **signed by all members of the IBH implementation team in the practice.** |
|  | *Prerequisite # 1:* Copy of current NCQA Recognition indicating recognition at Level 2 or greater. |
|  | *Prerequisite # 2:* Copy of team completion of [Maine Health Access Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) **(only one per site needed).** |
|  | *Prerequisite # 3:* Copy of sample standardized and a sample customized EHR report or screenshot demonstrating capacity to report screening scores for depression, anxiety and substance use disorder.  *\*Please remove any protected health information (PHI) before submitting sample reports* |
|  | *Prerequisite # 4:* If practice with less than 3-4 FTE providers and 5,000 attributed patients:  Copy of Memorandum of Agreement/formal affiliation  Agreement to include: how the practice will work with other primary care providers to meet the conditions of participation, Contract deliverables, and collectively share IBH services and resource payments. |
|  | Application Form, filled out completely |
|  | Written response to four essay questions |
|  | Completed Application Package Checklist |

**Completed application packages – including completed checklist - should be received by 5:00 PM on 11/16/15. Email application package to:** [**CTCRI@umassmed.edu**](mailto:CTCRI@umassmed.edu)

**For questions, contact:**

Michele Brown

Project Coordinator

508.421.5919

**Application for IBH Pilot Program**

**Practice Information**

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Zip \_\_\_\_\_\_

Phone: \_\_\_-\_\_\_-\_\_\_\_

Practice Tax ID Number (TIN): \_\_\_\_\_\_\_\_\_

Type of Practice (e.g. Adult, Family, FQHC, Hospital-Based Clinic) \_\_\_\_\_\_\_\_\_\_

Multisite practice: Yes/No\_\_\_\_

(If yes) Identify other practice sites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single site applying with other primary care practices: Yes/No\_\_\_\_

(If yes) Identify other practices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Champion Contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Leader who will be responsible for project implementation:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_-\_\_\_\_-\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **List name and NPI number for all Practitioners (MDs, DOs, NPs and PAs):** | | | |
| Name | NPI# | Name | NPI# |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Practice Payer Mix:** | | | | | |
| Payer | Number of Pts | % of Total Practice | Payer | Number of Pts | % of Total Practice |
| Medicare Adv |  |  | NHP-RI |  |  |
| Medicare FFS |  |  | Tufts |  |  |
| Medicaid |  |  | Insured Other |  |  |
| BCBS |  |  | Uninsured |  |  |
| United |  |  |  | | |

**Application**

**Prerequisites:**

1. Does your practice currently have PCMH NCQA Level two (or greater)? Yes/no

Level: \_\_\_\_\_ Year \_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_ 2011/2014 please provide copy with application;

1a. If your practice does not have level two NCQA currently but plans to obtain, what is the anticipated date?

2. Has the practice team completed the [Maine Health Access Evaluation Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool) for your practice? Yes/No

Total Score: \_\_\_\_\_\_\_\_\_ please provide self-assessment with application;

3. Does your practice have a fully implemented EHR system that has the capacity to generate registry reports with screening and re-screening scores for patients: depression, anxiety and SUD? Yes/No

4. Does the EHR system have the capacity to bill for BH services? Yes/No

If no, indicate plan for offsetting BH costs or billing for BH services.

Electronic Health Record: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;

Indicate plans if your practice is anticipating changing electronic health systems within the next two years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a copy of a sample standardized report for depression, anxiety and substance use with initial screening score and follow up scores (or screen shots demonstrating system capacity to generate registry reports).

4a. Does your practice have an attributed patient panel size of 5,000 or more patients? Yes/No

Total attributed patient panel size: \_\_\_\_\_\_\_\_\_; if less than 5,000 attributed patients, indicate practices that you will work with, together with practice attributed lives (or with a minimum of 2,500 attributed patients with 0.5FTE staffing plan:

|  |  |  |
| --- | --- | --- |
| **Practice** | **Location** | **Patient attributed lives** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please provide an executed Memorandum of Agreement indicating how practices will work together to meet deliverables, share behavioral health staff and financial resources.

Which cohort would you like to participate in?

Cohort 1: Begins January 2016

Cohort 2: Begins November 1 2017

Reason:

**Application**

**Additional Application Information**

1. Does your practice currently employ a BH staff member(s)? Yes/No\_\_\_\_\_\_\_

If yes, please complete chart below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | # of people | Hours per week | Contract or employee | Co-located or integrated |
| Psychologist |  |  |  |  |
| LICSW |  |  |  |  |
| Licensed Social Worker |  |  |  |  |
| Nurse Practitioner (Psychiatric) |  |  |  |  |
| Psychiatrist |  |  |  |  |
| Other |  |  |  |  |

2. Does your practice presently have a compact for BH? Yes/No\_\_\_\_\_

If yes, indicate compact information:

Name of organization/person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate behavioral health conditions that are covered in the compact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Has your practice previously participated in an IBH training program? Yes/No\_\_\_\_\_

If yes, please describe the program and results:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **N/A** | **Comment** |
| If your practice does not have IBH clinician in place with a staffing ratio of 1 FTE for every 5,000 attributed lives (or 0.5FTE for 2,500 attributed lives) can you hire IBH staff within 2 months of award notification? |  |  |  |  |
| Can you provide workspace for the IBH clinician central to primary care? |  |  |  |  |
| Can you implement an IBH staffing plan for patients to be able to access IBH services with same day to no later than 72 hour access from original referral? |  |  |  |  |
| Can you establish billing systems for billing of IBH services? |  |  |  |  |
| If planning to hire non-independently licensed IBH providers, can you establish supervision of these individuals? |  |  |  |  |
| Can evidence-based screening tools for depression, anxiety and substance use be in place for all patients annually within 3 months of award notification? |  |  |  |  |
| For the evidence-based screening tools, can the PHQ9 (depression), GAD7 (anxiety) and CAGE-AID (alcohol and drugs) be primary tools used? *If no, please justify rationale for using other screening tools in the essay section.* |  |  |  |  |
| Can baseline reports be provided on screening rates for depression, anxiety and substance use within 1 month of award notification? |  |  |  |  |
| Can monthly practice registry reports on screening results (initial and follow-up as indicated by score on initial) occur within 4 months of award notification? |  |  |  |  |
| Can patients be re-screened within 6 months of initial screening if score on any screening is in moderate-severe range? |  |  |  |  |
| Can the practice agree to monthly on-site IBH consultation over 2 years with a minimum of physician/clinical IBH champion, nurse care manager, IBH provider, administrative/operational liaison, and IT professional present? |  |  |  |  |
| Can the practice commit to monthly team meetings separate from the IBH consultation meetings as a way to follow through with recommendations made by consultant and engage all team members? |  |  |  |  |
| Can weekly NCM/IBH clinician meetings occur to provide case consultation on shared patients and review of high-risk/high-utilizer patients? |  |  |  |  |
| Does site have a workflow in place for management of high-risk/high-utilizer patients with behavioral health conditions or chronic health conditions and behavioral health? |  |  |  |  |
| If the site does not have a workflow in place for management of high-risk/high-utilizers patients with behavioral health conditions or chronic health conditions and behavioral health, is there a commitment to creating one? |  |  |  |  |
| If there are no compacts in place with specialty mental health, is there a commitment to obtain at least one within 3 months of award notification? |  |  |  |  |
| Can the practice track and coordinate care of referrals to specialty mental health to report whether first appointment occurred? If not, can practice assist in identifying barriers to specialty mental health referral and track? |  |  |  |  |
| Can the practice create a population health approach targeted towards a chronic disease and behavioral health condition that are connected in the performance year (year 2)? |  |  |  |  |

**Essay Questions:**

**Please provide a response to each question (limit responses to a maximum of 500 words per question)**

1. The goal of this CTC-RI pilot is to help practices transform into PCMHs with a strong IBH infrastructure by either hiring IBH providers or supplementing unbillable IBH provider time to complete key aspects of care coordination. How do you intend to use the funds from CTCI-RI to transform your IBH practice?
2. One of the qualities of successful IBH practices in the PCMH model is strong physician and/or organizational leadership with commitment to practice transformation and broad support from practice team.
   1. Please describe the physician, NCM and top organizational leadership commitment to IBH transformation in your practice.
   2. Please identity the qualifications of the person who will be designated at project manager for this project
   3. Is there broad support from all providers (including NCM, behavioral health) in the practice?
   4. What would the largest opponent of IBH in your practice identify as the barriers in moving IBH forward and how would the organization respond?
3. Based on the results of the baseline assessment tool Maine Health Assessment Tool what are the top three areas of assistance your site will plan to utilize the services of the IBH consultant for?

4. To justify long-term sustainability, how do you envision your program reducing ED utilization as it relates to behavioral health symptoms driving medical and/or behavioral health utilization?

**CTC-RI Selection Committee Policy and Procedure (2015)**

We anticipate that we may have more applications than available slots, therefore it is critical that applications for participation in CTC-RI IBH Pilot Project be reviewed and scored in an objective, fair, and transparent manner. The following reflects CTC’s policy and procedure for application review:

**Conflict of interest:**

Reviewers must disclose any potential conflict of interest related to a specific applicant. A conflict of interest is defined as a real or potential monetary benefit or having an organizational affiliation with the applicant. The Selection Committee will discuss the potential conflicts of interest and make a determination of whether a conflict of interest exists. If so, the reviewer must recuse themselves from the review of that application.

**Selection Committee Group Process for Review of Total Scores:**   
The Selection Committee will convene in November 2015, when a primary and secondary reviewer will present and discuss the rationale for scoring. The group will then discuss the ratings to reach consensus on application scoring. Final scores will be entered into a spread sheet, totaled and divided by the number of scores to reach a mean score for each criterion and an overall total score for the application. Once this process has been completed for all applications, the applications will be rank-ordered by anticipated developmental stage. *The Selection Committee reserves the right to interview applicants if further review is warranted.*

**Review Criteria:**   
All reviewers will read and score each application independently using the scoring form and criteria established by the CTC Selection Committee. Reviewers will submit their scores to CTC Management by December 2015. CTC Management will compile all scores into one table per application with a total number of points. The maximum number of points is 70. Applications will be rank-ordered by anticipated developmental stage.

We anticipate that we will select up to 16 practice sites (or 30,000 attributed patient lives individuals, whichever comes first). These practices will enter CTC in Stage 1-Start-Up and be assigned to Cohort 1 or Cohort 2.

In the event of a tie, the following criteria will be used:

1. Completion of application-submitted on time and complete;
2. Number of Medicaid members-we desire a balance in population served;
3. Diversity in patient demographics; and/or
4. Previous experience with IBH model-practice can serve as a mentor.

*Prerequisites are highlighted in yellow and are required elements for acceptance so are not assigned a point value.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NCQA (max 2)** | **Score** |  | **EHR Capacity (max 8)** | **Score** |  | **% Medicaid (max 1)** | **Score** |
|  |  |  |  |  |  |  |  |
| Level 1 achieved | 0 |  | Ability to bill for BH services | Add 1 point |  | <10 | 0 |
| Level 2 achieved | 1 |  | Registries for depression (PHQ-2 and PHQ-9) | Add 1 point |  | >10 | 1 |
| Level 3 achieved | 2 |  | Registry for anxiety | Add 1 point |  |  |  |
|  |  |  | Registry for SUD | Add 1 point |  |  |  |
|  |  |  | Registry for high risk patients that based on ED/IP | Add 1 point |  |  |  |
|  |  |  | Standard plus custom reporting capability | Add 1 point |  |  |  |
|  |  |  | Designated staff/support | Add 1 point |  |  |  |
|  |  |  | Can provide quarterly screening reports for depression, anxiety and SUD | Add 1 point |  |  |  |
| **# Providers/ Do we take this out as it is a pre-requisite Patients (max 3)** | **Score** |  | **CurrentCare (max 5)** | **Score** |  | **BH (max 8)** | **Score** |
| <2500  attributed patients | 0 |  | No plans to use | 0 |  | Compacts (inclusive of meeting needs of patients with serious BH/SUD needs | 1 |
| 2500-3000  attributed patients | 1 |  | Enrolling patients | Add 1 point |  | Co-located | 2 |
| 3001-4999  attributed patients | 2 |  | More than 30% enrolled | Add 1 point |  | Fully integrated | 3 |
| >5 FTE and >5000 attributed patients | 3 |  | CurrentCare Viewer | Add 1 point |  | Able to provide space for BH staff | Add 1 point |
|  |  |  | CurrentCare Hospital Alerts | Add 1 point |  | Ability to report on number of unique patients with BH encounters | Add 1 Point |
|  |  |  | Direct Account | Add 1 point |  | Designated BH staff hired | Add 1 point |
|  |  |  |  |  |  | Tracking referrals to specialty mental health capacity | Add 1 point |
| **BH Capacity (max 2)** | **Score** |  |  |  |  | **Patient Involvement**  **(max 2)** | **Score** |
| None | 0 |  |  |  |  | Active patient involvement | 1 |
| Some experience with BH | 1 |  |  |  |  | High-level of patient involvement | 2 |
| High level of BH experience embedded in practice | 2 |  |  |  |  |  |  |

**Reviewer Scoring Notes**

1. NCQA: A total of 2 points are available. Practice must complete [Maine Health Access Tool](https://www.surveymonkey.com/r/MaineHealthAssessmentTool). Assign 0 points if practice has achieved Level 1; 1 point if Level 2; and 2 points if Level 3.
2. # of Patients: A total of 3 points are available. Assign 0 points for practices with less than 2500 patients; assign 1 point if 2500-3000attributed patients; 2 points if 3001-4999 attributed patients; and 3 points if greater than 5 FTEs, and greater than 5000 attributed patients.
3. BH Capacity: A total of 2 points are available. Assign 1 point if the practice has some experience with BH; and 2 points if there is a high level of BH experience embedded in the practice.
4. EHR Capacity: A total of 8 points are available. Assign 1 point if the practice has at least one provider with the ability to bill for BH services, and registries for depression (PHQ-2 and PHQ-9); add 1 point if practice has additional registries for anxiety, SUD, or high risk patients that are based on ED/IP; add 1 point for standard plus custom reporting capability; add1 point for standard plus custom reporting capability; add 1 point if practice has designated staff or other support; or add 1 point if practice can provide quarterly screening reports for depression, anxiety and SUD.
5. Current Care: A total of 5 points are available. Assign 0 points for practices without plans to use Current Care. Add 1 point for each item that the applicant reports: enrolling patients, more than 30% of practice enrolled, using Hospital Alerts, using CurrentCare Viewer, has Direct account.
6. % Medicaid: A total of 1 point is available. Combine percentage of Medicaid and NHP patients
7. BH: A total of 8 points are available. Assign 1 point if practice uses only compacts with BH provider; Assign 2 points if practice has co-located BH; Assign 3 points if practice has fully IBH provider. Add 1 point each for the following: Able to provide space for BH staff, ability to report on number of unique patients with BH encounters, designated BH staff hired, and tracking referrals to specialty mental health capacity.
8. Patient Involvement: A total of 2 points are available. Assign 1 point if applicant reported active patient involvement; and 2 points if there is a high level of patient involvement.
9. Essay Questions: A total of 10 points is possible for each question. 2 points if question answered; an additional 2-3 points if response demonstrated organizational interest/commitment and moderate degree of readiness; additional 4-5 points for above average response suggesting that the practice has high degree of readiness, has begun transformation work and is making progress towards IBH transformation.

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| **Reviewers Score Sheet** | | | | | | | | | | | | | | | | | |
|  | Prerequisites (check if met) | | | | Application Questions | | | | | | | | Essay Questions | | | |  |
| App # | PR 1 | PR 2 | PR 3 | PR 4 | NCQA  *(max 2)* | # of Prov/ Pt (max 3) | BH Cap  (max 2) | EHR Cap  (max 8) | CurrCare  (max 5) | % Medicaid  (max 1) | BH  (max 8) | Pt Inv  *(max 2)* | E #1 *(max 10)* | E #2 *(max 10)* | E #3  *(max 10)* | E #4  *(max 10)* | **Total**  ***(max 69)*** |
| **1** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **8** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **9** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **10** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **11** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **12** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **13** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **14** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **15** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **16** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **17** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **18** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **19** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **20** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |