Project Title	*E5: Enhanced Care Coordination for High-Need Populations*
Project Objective	This project aims to develop comprehensive care coordination/management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions. These services are intended to maintain or improve an individual's functional status, increase that individual's capacity to self-manage their condition, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.
Target Population	• Adults (18 years or older): individuals with behavioral health disorders (specifically, serious mental illness or Substance Use Disorders, including opioid addiction) with or without poorly managed or uncontrolled co-morbid chronic physical and/or social factors (such as homelessness) that are barriers to community living and well-being • Children (< 18 years): children diagnosed with chronic serious emotional disturbance • Developmentally Disabled (DD) population Aged Blind and Disabled (ABD) population with co-occurring behavioral health disorders
Target Participating Organizations	• Primary care providers • Behavioral health providers (mental health and SUD) • Community-based social support service organizations
Related Projects	• IDNs implementing this project should coordinate with and build on the Core Competencies being developed as part of Project B1 (integration of behavioral health and primary care) • Health information technology (HIT) requirements for this project should be incorporated into the IDN's HIT planning process in conjunction with Project A2 (HIT Infrastructure to Support Integration) • Workforce requirements for this project should be incorporated into the IDN's Workforce Capacity Development Implementation Plan in conjunction with Project A1 (Behavioral Health Workforce Capacity Development)
Project Core Components	• IDNs implementing this project will define its specific care coordination models and exact target populations; however, core required elements of any model include: o Identified care teams that include care coordinator/managers, primary care providers, behavioral health providers o Systematic strategies to identify and intervene with target population o A comprehensive core assessment and a care plan for each enrolled patient, updated on a regular basis o Care coordination services that facilitate linkages and access to needed primary and specialty health care, prevention and health promotion services, mental health and substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources o Transitional care coordination across settings, including from the hospital to the community o Technology-based systems to track and share care plans and to measure and document selected impact measures o Robust patient engagement process around information sharing consent o Coordination with other care coordination/management programs or resources that may be following the same

	patient so that to the extent possible, only one care coordinator/manager is playing a lead role in managing the patient's care plan
Process Milestones	As part of the 2017-2018 semi-annual IDN reporting process, IDNs are required to demonstrate that organizations participating in this project (as identified in the approved IDN Project Plan) have achieved the following process milestones during, or in advance of, the timeframes noted. **Jan-Jun 2017 Reporting Period** **1. Development of implementation plan, which includes:** a. Implementation timeline b. Project budget c. Work force plan: staffing plan; recruitment and retention strategies d. Projected annual client engagement volumes e. Key organizational/ provider participants **2. Design and development of clinical services infrastructure, which includes identification or development of:** a. Description of target population and eligibility criteria, including rationale for intervention with this target population that aligns with the goals of the Transformation Demonstration b. Standardized assessment tool(s) c. Patient assessment, treatment, management, and referral protocols, including: i. Method for rapidly identifying and engaging the target population in community delivered care or self-management strategies ii. Model for ongoing care coordination/management and intervention with the target population, indicating strategies and mechanism through which the model will improve management of the chronic conditions d. Roles and responsibilities for care team members e. Training plan f. Training curricula, including standard set of care coordinator/manager knowledge and skills requirements and qualified training resources for care managers/coordinators g. Agreements with collaborating organizations, including community-based social support organizations

h. Evaluation plan, including metrics that will be used to measure program impact (e.g., number of successful linkages to social support services, change in utilization of ED and inpatient services for those enrolled/active for more than 3 months)
i. Mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to evidence-supported project elements

July-Dec 2017 Reporting Period

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

Jan-Jun 2018 Reporting Period

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

Jul-Dec 2018 Reporting Period

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