





The Integrated Care Technical Assistance Program (ICTA) is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

#### WHAT IS THE ICTA PROGRAM?





- >>> The Integrated Care Technical Assistance Program (ICTA) is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.
- >>> The ICTA Program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



#### **CORE COMPETENCY 1**



## Delivering Person-Centered Care Across the Care Continuum to Improve Patient Outcomes

- + 1.1 Triage/prioritize patients
- + 1.2 Personalize care planning
- + 1.3 Manage person centered care to integrate physical, behavioral, and social services
- + 1.4 Manage medications
- + 1.5 Integrate health information technology into daily workflow
- + 1.6 Leverage modern modalities of care (e.g. telemedicine)
- + 1.7 Implement privacy policies, managing consent, and applying confidentiality rules appropriately
- + 1.8 Implement a high standard of culturally informed customer service care at all levels of the organization

### **CORE COMPETENCY 2**



# Using Data and Population Health Analytics to Improve Care

- + 2.1 Convert data into protocols and interventions, particularly to support early identification of those at risk
- + 2.2 Implement effective, timely discharge planning
- + 2.3 Ensure effective, timely care transitions across systems and settings
- + 2.4 Share data inside and outside your organization
- + 2.5 Evaluate performance measure data
- + 2.6 Leverage analytics to support care management
- + 2.7 Implement continuous quality improvement strategies and principles

### **CORE COMPETENCY 3**





# Engaging Leadership to Support a Person-Centered, Value-Based Care

- + 3.1 Invest in infrastructure
- + 3.2 Develop a vision and strategy (including legal, regulatory, and business model) for sustainable, value-based care delivery
- + 3.3 Train and maintain workforce to advance a patient centered and team-based culture
- + 3.4 Communicate value-based payment models to Executives or Boards
- + 3.5 Develop partnerships that produce high value for the organization and sponsors
- + 3.6 Define the organization's approach to patient privacy and data governance
- + 3.7 Define and measure success for payers, providers, and patients.