



New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver
IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For
Year 3 (CY2018)
2018-6-30 v.27

FINAL DRAFT
Region 1 IDN

Contents

- Introduction 1
 - DSRIP IDN Project Plan Implementation (PPI) 2
 - DSRIP IDN Process Milestones..... 2
 - Soliciting Community Input: 2
 - Network Development: 3
 - Addressing the Opioid Crisis..... 5
 - Governance 7
 - Budget 9
- Project A1: Behavioral Health Workforce Capacity Development..... 14
 - A1-3. IDN-level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan 14
 - A1-4. IDN-level Workforce: Evaluation Project Targets 24
 - A1-5. IDN-level Workforce: Staffing Targets..... 27
- A1-5: Current Community Project Pilot Staffing..... 28
 - A1-6. IDN-level Workforce: Building Capacity Budget 30
 - A1-7. IDN-level Workforce: Table of Key Organizational and Provider Participants..... 35
- Project Scoring: IDN Workforce Process Milestones 38
 - A2-3. IDN HIT/HIE: Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan..... 39
 - A2-4. IDN HIT: Evaluation Project Targets 55
 - A2-5. IDN HIT: Workforce Staffing..... 56
 - A2-7. IDN HIT: Key Organizational and Provider Participants 63
 - A2-8. IDN HIT. Data Agreement..... 64
- Project Scoring: IDN HIT Process Milestones..... 65
- Project B1: Integrated Healthcare..... 66
 - B1-2. IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan..... 66
 - B1-3. IDN Integrated Healthcare: Evaluation Project Targets 103
 - B1-4. IDN Integrated Healthcare: Workforce Staffing 104
 - B1-5. IDN Integrated Healthcare: Budget **Error! Bookmark not defined.**
 - B1-6. IDN Integrated Healthcare: Key Organizational and Provider Participants 116
 - B1-7. IDN Integrated Healthcare: IDN Governance Leadership Sign-off 116
 - B1-8. Additional Documentation as Requested in B1-8a-8h 117

B1.8a CCSA Utilization	118
B1.8a Pediatric CCSA Utilization	146
B1.8b Multi-Disciplinary Care Team Members by Practice	147
B1-8c. Required Training	148
B1-8d. Non Direct Care Staff Training	149
B1-8e. Multi-Disciplinary Core Team Schedule.....	150
B1-8h. Documented Workflows and/or Protocols:	153
B1-9. Additional Documentation as Requested in B1-9a - 9d.....	165
B1-9a. Report on progress toward coordinated care designation.....	165
B1-9b. MAT.....	165
B1-9c. HIT	167
B1-9d	169
B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation	174
IDN Community Project Implementation and Clinical Services Infrastructure Plan	178
C-1. IDN Community Project: Core Components, Process Milestones, Training and Evaluation Project Plans	178
C-2. IDN Community Project: Evaluation Project Targets	188
C-3. IDN Community Project: Workforce Staffing	191
C-4. IDN Community Project: Budget.....	192
C-5. IDN Community Project: Key Organizational and Provider Participants.....	193
C-6. IDN Community Project: Standard Assessment Tools	193
C-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals	194
C-8. IDN Community Project: Member Roles and Responsibilities.....	195
C-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3.	195
Project Scoring: IDN Community Project Process Milestones	197
IDN Community Project Implementation and Clinical Services Infrastructure Plan.....	199
D-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan.....	199
D-2. IDN Community Project: Evaluation Project Targets.....	211
D-3. IDN Community Project: Workforce Staffing	215
D-4. IDN Community Project: Budget.....	215
D-5. IDN Community Project: Key Organizational and Provider Participants	217

D-6. IDN Community Project: Standard Assessment Tools.....	217
D-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals	218
D-8. IDN Community Project: Member Roles and Responsibilities	218
D-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3	220
Project Scoring: IDN Community Project Process Milestones	222
IDN Community Project Implementation and Clinical Services Infrastructure Plan	223
E-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan.....	223
E-2. IDN Community Project: Evaluation Project Targets	231
E-3. IDN Community Project: Workforce Staffing.....	232
E-4. IDN Community Project: Budget	232
E-5. IDN Community Project: Key Organizational and Provider Participants.....	234
E-6. IDN Community Project: Standard Assessment Tools	235
E-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals	235
E-8. IDN Community Project Member Roles and Responsibilities	236
E-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3	236
DHHS Project Scoring: IDN Community Project Process Milestones	237
Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning	238
DSRIP Outcome Measures for Years 2 and 3	240
Appendix A1-3:.....	241
Appendix B1-2: DH-Heater Rd and WCBH.....	248
Appendix B1-2: VRH and CA	254
Appendix C-1	260
Appendix D-1	264
Appendix E-1	270

Introduction

The Centers for Medicare and Medicaid Services (CMS) approved New Hampshire’s application for a five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs are charged with participating in statewide planning efforts and selecting and implementing community-driven projects. 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.

This Reporting Guide is for use by the IDNs to identify required documentation for achieving project requirements according to the Special Terms and Conditions of the DSRIP Waiver. The state will use the information to review and document the IDNs’ progress on project implementation and to award incentive payments. IDNs are required to complete separate implementation plans for each of their statewide projects (i.e., workforce, health information technology and alternative payment models), core competency project, and community-driven projects. Required deliverables must be submitted to the Department of Health and Human Services by July 31, 2017 and within 31 days after each six-month reporting period, as indicated in below. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Submission of the semi-annual report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints, your attachments should also be uploaded separately in the original file version as well (ms project, ms excel, etc.). Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable for which it is being submitted.

See below for illustration of attachment for project B1 deliverable 2A:
Attachment_B1.2A

For the Reporting Period:	Process Measures Reporting Due to DHHS no later than:
January 1, 2017 – June 30, 2017	July 31, 2017
July 1, 2017 – December 31, 2017	January 31, 2018
January 1, 2018 – June 30, 2018	July 31, 2018
July 1, 2018 – December 31, 2018	January 31, 2019

To be considered timely, supporting documentation must be submitted electronically to the State by the dates indicated above into each IDN’s semiannual reporting folder. For questions, contact:

Kelley Capuchino
Senior Policy Analyst
NH Department of Health and Human Services
Division of Behavioral Health
129 Pleasant St
Concord NH 03301

DSRIP IDN Project Plan Implementation (PPI)

Each IDN was required to develop implementation plans for the July submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points, evaluation metrics, and Community Input, IDN Network changes, Opioid Crisis Update, Governance, and Budget narrative accompanied by a budget spreadsheet.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Please provide a budget of actual expenditures and projected costs to complement narrative.

DSRIP IDN Process Milestones

DHHS will use the tool below to review and document each IDN's Implementation activity. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
PPI	Project Plan Progress, including: Community Input, Network, Opioid Crisis Update, Governance, and Budget	Narrative and budget spreadsheet	Met	Met	Met	

Soliciting Community Input:

Gaining community input has been foundational to all IDN-1 planning since the beginning of the 1115 Waiver program in Region 1. Leaders across IDN-1 recognize the importance of listening to key stakeholders to understand the complexities of the current system of care and of engaging these stakeholders to plan and implement the changes they would like to see. Additionally, the IDN1 Medical Director and Member of the IDN1 Executive Committee participate as Chair and Co-chair of the Community Engagement Research Board for Synergy, resulting in their regular engagement and updates from community voices as well as continuous learning about the value and nature of meaningful community engagement.

Initial engagement efforts included:

- Comprehensive Behavioral Health Needs Assessment (Completed in 2016)
- Community Members in Governance Roles (Ongoing)
 - Ongoing efforts to solicit community, patient/family membership on the IDN1 Executive Committee were undertaken during January-June, 2018
- Community Members in Project Selection Roles (Ongoing)

- *Whenever possible IDN1 project teams have been working with identified patient engagement boards and community members to inform project design and implementation undertakings (Updates for January-June, 2018)*
- Community Member input to Integration Design (Ongoing)
- Listening Tour (First Round in 2017, 2nd Round with B1 Partners in 2018)
 - *IDN1 Admin Team has been meeting individually with B1 partner organizations throughout the January-June, 2018 implementation timeframe*
- IDN1 Medical Director has been in regular attendance at the All Together Community Forum on SUD Care in the Upper Valley

During the period of July to December 2017, the Region 1 IDN team continued with the following activities to engage and solicit community input;

- Ongoing outreach for Community member voices included on IDN1 Knowledge Exchanges, Advisory Council, Finance Committee and Executive Committee
- Participation in Workforce efforts to continually solicit increased community, patient and family participation

These efforts along with those identified above were expanded during the January- June, 2018 SAR period.

Network Development:

(All Updates for the July-December, 2017 and January-July, 2018 period shared in bullet format)

To date, IDN-1 has been building a network of care providers and community supports to address the many needs of the Medicaid members in region 1. The process has been open, inclusive and consensus-driven. The following paragraphs define the Network Development efforts to date, many of which will continue into the future:

Commitment of Partners: IDN-1 has provided information on the Waiver to all interested organizations. The IDN has requested letters of commitment to become formal IDN “Partners” throughout the planning phase. Committed Partners are provided with a governance seat on the Advisory Council and are included in IDN-1 formal communications and planning.

Updates for Semi Annual Period: July-December, 2017

- Continuation of partner outreach and engagement

Updates for Semi Annual Period: January-June, 2018

- IDN1 Admin team has been engaging with newly on boarded partners Mascoma Community Health Center, Counseling Associates (2017) and bringing new organization applicants to the Executive Committee for vote. The Committee voted in June, 2018 to add Stepping Stone and Next Step, peer support and respite centers in Claremont and Lebanon, respectively as partners in the next reporting period. The IDN had already engaged the leadership but the organization was previously not ready to join the IDN.

Identification of Integrated Core Team Partners: IDN-1 has used Medicaid Claims data to identify the providers that serve the current Medicaid population in region 1. The IDN-1 administrative team worked

with DHHS during Spring, 2017 to confirm that the majority of Medicaid Member-serving providers are IDN-1 Partners and that the providers who see large numbers of Medicaid members are intimately engaged with the 1115 waiver program.

Updates for Semi Annual Period: July-December, 2017

- The IDN1 team continued to target new partner involvement in the B1 project focusing on expanded participation across partners with the largest attributed population of Medicaid members
 - Inclusion of the following B1 agencies in the active project cohort
 - Cheshire Medical Center
 - Counseling Associates
 - Valley Regional Hospital
 - Monadnock Family Services
 - Actively partnering with the following B1 partners on developing B1 scope of works:
 - Newport Health Center
 - Alice Peck Day Memorial Hospital
 - Monadnock Community Hospital

Updates for Semi Annual Period: January-June, 2018

- IDN1 has taken the expanded data made available through DHHS and the MCO's in the January- June SAR period to refine and hone the project implementation efforts across the B1 project scope. Details on involved partners included in sections A1-7, B1-10 below.

RFA Process to Select and Deploy Projects: IDN-1 has implemented a formal Request for Application Process to solicit applications from Partners to deploy a project. This process has helped formalize the network of providers that will work toward transformation of the delivery system.

Updates for Semi Annual Period: July-December, 2017

- IDN1 continued with the wave process for RFA requests for the B1 project from July-December, 2017
 - The RFA Process was active for B1 submissions during the following months:
 - Wave I Round III: September – October, 2017
 - The next session of the RFP opens:
 - Wave II Round I: January- February, 2018

Updates for Semi Annual Period: January-June, 2018

- IDN1 held Round I RFP for B1 projects and closed the session in March, 2018
- Given the limited number of remaining B1 organizations pending implementation and the high touch onboarding process underway with the IDN1 team April, 2018 marked the start of an open submission period to run through August, 2018. This shift in RFP process has allowed for more direct connection with project teams during their Scope of Work development and accommodated for the timeline needs of IDN1 partners. In September, 2018 the IDN admin team will review the remaining non-implementing B1 partners and

make final decisions on each partner individually as to if and how to best bring their B1 project online.

Contracts: IDN-1 has drafted contracts to formalize participation in the projects selected through the RFA process.

Updates for Semi Annual Period: July-December, 2017

- Throughout July-December contracts have been executed for new B1 projects
 - B1: Cheshire Medical Center and Monadnock Family Services
 - B1: Valley Regional Hospital and Counseling Associates
- Previously reported projects:
 - C1: Monadnock Family Services
 - E5: Valley Regional Hospital
 - D3: DH Psychiatry

Updates for Semi Annual Period: January-July, 2018

- The E5 project underwent a shift in contracting in the January-June SAR period. This is addressed further in the Project E section below.
- The IDN1 team is in contract development for B1 projects with:
 - Alice Peck Day Hospital
 - Newport Health Center
 - Scope of Work for General Internal Medicine at DH

Community Supports Identification and Engagement: IDN-1 projects have identified potential community supports providers, some of which have already been involved with the waiver and some of which are new. Community supports partners are to be engaged through the projects.

Updates for Semi Annual Period: July-December, 2017

- Expanded involvement in community partner groups such as the:
 - Public Health Networks in Cheshire, Sullivan counties
 - Participation at the All Partner meeting in Sullivan County
 - Participation in the Continuum of Care network in the Upper Valley, Sullivan, and Cheshire Counties

Updates for Semi Annual Period: January-June, 2018

- IDN1 has not formally added any new community support agencies; Stepping Stone/Next Step will be formally added in the next reporting period.
- The IDN1 team continues to partner and engage with community initiatives underway within the IDN's designated counties.

Addressing the Opioid Crisis

In fall of 2016, a systemic gap analysis was performed to determine the extent of the opioid crisis in the Region, existing SUD services, and both the need and the opportunities for expansion. Highest need areas identified in this assessment have addressed IDN1 ongoing plan strategies to address screening;

workforce requirements; barriers to accessing care; professional, institutional and community stigma; referral and coordination processes; documentation and confidentiality issues; multidisciplinary team approaches; levels of care; special needs populations; and shared care plans. Integral to the work in all of these areas is a robust plan for workforce development. Projects are planned for recruitment, retention, education and training. These initiatives are aligned with the statewide workforce plan, and will be coordinated with other IDNs. *See the A1 Implementation Plan section for additional information on these process milestones.*

IDN-1 has been involved in the ongoing coordination efforts across IDN providers to align various funding and projects addressing the opioid crisis. Some newly awarded funds are;

- Support from the Foundation for Healthy Communities to develop a model MAT program at
 - Alice Peck Day Memorial Hospital in partnership with the American Academy for Addiction Psychiatry
 - IDN1 is in continued meetings with APD to develop a B1 project that builds on integrative infrastructure that has evolved from the MAT program implementation.
 - For expansion of MAT at Dartmouth Hitchcock Memorial Hospital
 - IDN1 through the DH/WCBH B1 project is coordinating with all internal DH projects including leveraging internal MAT resources
 - For expansion of MAT at Cheshire Medical Center/Dartmouth Hitchcock Keene
 - IDN1 through the CMC/WCBH B1 project will coordinate with all internal CMC projects including leveraging internal MAT resources
- Cheshire Medical Center received a 3-year, [REDACTED] grant from HRSA in June, 2017 to develop a network addressing current barriers to effective prevention and treatment related to all controlled substances
 - IDN1 is staying informed on the development of the HRSA grant and any potential areas for synergy with IDN projects and goals
- IDN1 continues to serve as a connector between network partners and new funding opportunities related to expansion of SUD services. Given the notification of additional funding coming into the state in fall, 2018 the IDN1 team will work to connect partners and support their efforts to pursue new funding streams.

Other initiatives the IDN has been involved with over the last 6 months are;

- All Together SUD Meetings in the Upper Valley
- The Governor's Opioid and Other Drugs Commission Healthcare Taskforce
- NH Commission on Primary Care
- Insurance Department Advisory Board on Behavioral Health and Addiction
- Clinical Trials Network
- Involvement on the NHBDAS contract to expand MAT with the Center for Excellence
- Dartmouth- Hitchcock Substance Use Mental Health Integration Initiative

Additionally, IDN-1 membership and staff have participated in MAT expansion training, met with staff from the Center for Technology in Behavioral Health, and worked to develop the Perinatal Addiction

Treatment Program in the Region after determining the acuity of this need. *Please see the D3 Implementation Plan section for additional detail on the PATP expansion project.*

The IDN1 team continues to coordinate wherever possible with partners on activities targeting addressing the opioid crisis and is working to stay engaged across all of the ongoing initiatives within the region.

Governance

IDN-1 formalized its governance structure in the late summer of 2016 and it has been in operation ever since. The governance structure is described in detail within the IDN-1 Project plan which was approved by DHHS in the fall of 2016. The following paragraphs define the Governance efforts to date, many of which will continue into the future:

Executive Committee Periodic Meetings and Briefings: The IDN-1 Executive Committee is the primary governance body of the IDN. The EC is comprised of 4 community members and 7 institutional members who represent the stakeholders of IDN-1. The EC met monthly throughout 2017 and had 3 interim sessions additionally. The EC has taken a central role in the IDN-1 RFA process and has made its first round of project selections. The EC has been kept informed and apprised of IDN-1 activity through regular communications, a newsletter, and the IDN-1 website.

Updates for Semi Annual Period: July-December, 2017

- Updates to the EC membership
 - Inclusion of representatives from Claremont School System, Headrest and Clinical Staff at Alice Peck Day Hospital

Updates for Semi Annual Period: January-June, 2018

- Given the term timeframes for EC members there were 6 members who as of June, 2018 had served a full 2 year term. The IDN Admin Team confirmed continued interest in membership with these individuals as well as opened up the membership seats to the full IDN Advisory Council for nominations. With limited response from the IDN Advisory Council all of the open member's slots were reconfirmed by their existing representatives except for one. The IDN team is continuously pursuing nominations for patient and family member representation on the council.
- The Executive Committee chose to reconfirm the current Chair and Vice Chair for a 2 year term.

Advisory Council Periodic Meetings and Briefings: The IDN-1 Advisory Council is a broad inclusive body that has representation of all stakeholders and partners and that advises IDN-1. The Council has been kept informed and apprised of IDN-1 activity through regular communications, a newsletter, and the IDN-1 website.

Updates for Semi Annual Period: July-December, 2017

- Region 1 continued with scheduled Advisory Council meetings on September 18, 2017

Updates for Semi Annual Period: January-June, 2018

- Region 1 held a Winter, 2018 Advisory Council on February 28th with 70+ attendants
- The following agenda guided the Winter session:

Time	Topic	Leader
8:30 – 9:00	Networking Coffee	
9:00 – 9:15	Welcome & Updates	Ann Landry, Region 1 Executive Director & Sally Kraft, MD, Executive Co-Sponsor, VP Pop Health, DHMC
9:15 – 9:55	Tools for Engaging Patients & Families	Tanya Lord, Director, Patient and Family Engagement at Foundation for Healthy Communities
9:55 – 10:40	Region 1 Projects in Review: Models, Successes & Opportunities <ul style="list-style-type: none"> • Integrated Health Care Projects • Community Projects 	Jessica Powell, Region 1 Program Director, Integrated Healthcare & Community Project Teams
10:40– 11:25	Region 1 Projects Panel Discussion	Integrated Healthcare & Community Project Teams
11:25 – 11:55	Networking Lunch	
11:55 – 12:05	What’s Next for Partners with Technology, Data & Measurement?	Mark Belanger, Director, Region 1 HIT
12:05 – 12:55	The Evolving Landscape, Shifting Payments and the Development of an Alternative Payment Model	Lynn Guillette, VP, Payment Innovation, Dartmouth-Hitchcock System
12:55 – 1:00	Wrap-Up & Next Steps	Admin Lead Team

Finance Governance: IDN-1 added additional partners to its Finance Committee to enhance the level of expertise around Alternative Payment Model (APM) strategy development. The Committee will now focus both on the oversight of the budget and the strategy development and implementation of an APM in Region 1. The Finance Committee will also play an integral role in identifying how IDN 1 will partner with the Managed Care Organizations and larger IDN 1 partners in adapting to the pending alternative payment models.

Updates for Semi Annual Period: January-June, 2018

- The chair of the IDN1 Finance Committee participated in many statewide meetings throughout the semi-annual period including the APM roadmap discussions facilitated by UNH
- The IDN1 Finance Committee attempted to host a How to Training session on preparing partners for Risk Sharing Contracts in June, 2018 but due to illnesses and then technical difficulties, the session is postpone until late Summer 2018.

Data Governance: IDN-1 launched a Data & IT Workgroup as a sub-committee of the Executive Committee. One function of the Workgroup is data governance. The workgroup has been working through issues of patient privacy including preparedness for information sharing between organizations that serve a single patient's needs.

Updates for Semi Annual Period: July-December, 2017

- Region 1 continued with scheduled Data & IT workgroup meetings bi-weekly from July-December
 - This group stewarded the progress across data reporting and IT decision making in IDN1 including
 - Review of IT workflows and implementation protocols
 - Review of IT vendor selection and contracts
 - Support of MAeHC, as the IDN data aggregator, and for the reporting measure process

Updates for Semi Annual Period: January-June, 2018

- The IDN1 team used the HIT/Data workgroup as a platform for the ongoing Privacy and Consent discussions during the January-June SAR period. The workgroup relaunched in May/June, 2018 with a transitioned focus to Quality Reporting as well as the ongoing IT deployment.
 - As the IDN1 partner organizations transition to a more reporting focused operation there was a need for IDN supported group support and information sharing. The existing HIT/Data group seemed like the natural place for this work.

Budget

IDN-1 has continued through the project implementation and capacity building stages of project development to invest in the learning infrastructure of our region. Supporting activities have been undertaken and funded to target supporting knowledge exchange activities and the dissemination of evidence based and best practices across IDN partners. Much of the last semi-annual period has been invested in planning and using data-driven decision making to successfully target and allocate funding

										Totals
										\$ 17,570,122
										\$ -
										\$ -
	DGR3125B01									\$ -
										\$ 43,578
	DGR3125C01									\$ -
										\$ 49,802
										\$ 1,857
										\$ 548,514
A1	DGR3125D06									\$ 331,620
										\$ 2,278,500
										\$ 30,000
										\$ 485,000
A2										\$ -
										\$ 1,234,001
										\$ 751,399
B1										\$ -
										\$ 5,660,142
										\$ 2,665,023
					\$ 43,064.50	\$ 20,050.12	\$ 53,830.75	\$ 390,339.91	\$ 381,055.54	\$ 888,341
					\$ 7,556.00	\$ 110,540.00	\$ 93,000.00	\$ 351,170.50	\$ 326,074.50	\$ 888,341
					\$ 81,445.50	\$ (14,800.89)	\$ 54,393.25	\$ 388,293.75	\$ 379,009.38	\$ 888,341
Admin	DGR3125A01									\$ 1,848,580
										18,317,219

HIT: The IDN continues to contract with MAeHC to support and lead our health information technology work across IDN 1 partners. In agreement with the other IDNs, except IDN6, Region 1 has agreed to vendor contracts with CMT for Shared Care Planning and Event Notification, Kno2 for Direct Secure Messaging, and the MAeHC Quality Data Center for Data Aggregation and Quality Reporting. All contracts have been executed and deployment is underway with all technical services. See A2 Implementation Plan for additional details.

Updates for Semi Annual Period: July-December, 2017

- Shared Care Planning and Event Notification Service is Live. Contracts were signed with the vendor (Collective Medical Technologies), the product was configured, and rollout is underway with wave 1 Partners.
- Direct Secure Messaging Service is Live. Contracts were signed with the vendor (Kno-2) and rollout is underway with wave 1 Partners.
- Data Aggregation and Quality Reporting is Live. Contracts were signed with the vendor (Massachusetts eHealth Collaborative), the product was configured for NH Measures, and rollout is underway with Reporting Partners.

Updates for Semi Annual Period: January-June, 2018

- Three hospitals (Mary Hitchcock, Valley Regional, and Cheshire Medical Center) continue to automatically trigger notifications of emergency department and inpatient admissions, discharges, and transfers.
- Two hospital emergency department (Mary Hitchcock, Valley Regional) are accessing shared care plans in the ED.
- All wave 1 Partners have received technical advisory support from the IDN and Region 1 began development of Technical Implementation Guide to support technical components of the program.
- The Shared Care Plan is live with our first group of high complexity Medicaid Members (Dartmouth Hitchcock – Heater Road Primary Care)
- Quality Reporting services deployment is underway with Partners that will be reporting for the 2018 measurement period.
- One new partner (Monadnock Family Services) implemented Direct Secure Messaging with Kno2.

Integration Assessment: A contract was supported by the Region 1 Executive Committee to subcontract with the [REDACTED] to provide a tool for integration assessment across the B1 providers. The term of funding will cover 3 waves of assessment over the course of the next 18 months. This initial assessment will serve as the framework for the ongoing B1 rollout. Additionally, this subcontract will pay for quality improvement coach support across the B1 practices implementing in each wave. See B1 Implementation Plan section for additional details.

Updates for Semi Annual Period: July-December, 2017

- 2nd SSA session open to IDN1 B1 practices
- Continued rollout of B1 pilots

Updates for Semi Annual Period: January-June, 2018

- Completion of 2nd SSA submission period
- Review of the SSA roll-up report
- Targeted outreach and transparent data sharing with IDN B1 practices regarding SSA results and 6 month review

Training: IDN 1 is refining a multi-pronged training strategy which addresses the required project trainings, the desired trainings identified by partners, the opportunity to combine resources with other IDNS, the ability to leverage existing trainings offered in the State and the intent to create sustainability opportunities through these training dollars with “train the trainer” or “grown your own” strategies. Additionally, due to the geographic spread in Region 1, the training strategy intends to create access for all trainings either by rotating required in-person trainings across the different sub-regions and/or ensuring the audio and accompanying materials of every training (if possible) are accessible on the IDN 1 website. Please see A1 training section for more details.

Project A1: Behavioral Health Workforce Capacity Development

A1-3. IDN-level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan

See Appendix A1-3 for Excel Workplan of A1 Activities

Each IDN was required to complete an IDN level Workforce Capacity Development Implementation Plan, inclusive of the workforce needed to complete projects A1, A2, B1 and the IDN selected Projects C, D, and E.

Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. The narrative should relate to tables A1-4 through A1-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

In addition the narrative should include detail on each of the bullets below identifying the accomplishments and progress made on the strategies to address identified workforce gaps, identified barriers, and IDN plans to address identified barriers in:

- *Educating and training, including gaps in educational preparation of behavioral health providers' workforce readiness upon graduation;*
- *Recruitment of new providers and staff; and*
- *Retention of existing staff, including the IDN's targeted retention rates; and address:*
 - *Strategies to support training of non-clinical IDN staff in Mental Health First Aid;*
 - *Strategies for utilizing and connecting existing SUD and BH resources;*
 - *Additional strategies identified in the Statewide Workforce Capacity Strategic Plan; and*
 - *Any special considerations for workforce development related to the IDN's Community-Driven Projects, including unique training curricula and plans.*

The Region 1 team continued to focus its regional workforce efforts during this reporting period on securing staffing for the five projects and providing necessary training to the new hires and newly formed teams. Though the recruitment to hiring phase took longer than anticipated for all positions, Region 1 successfully filled twelve out of fourteen needed positions with the remaining two in recruit-to-hire across the five project team and 7 pilot teams. Through close collaboration and iterative processes with partners, the Region 1 operations team and the partner project leads skillfully identified opportunities to be nimble and adapt to the challenging recruitment environment in different sub-regions. For example, Region 1 amended its B1 contract with Valley Regional Hospital to incorporate recruitment incentive funds to secure the hiring of a licensed social worker for the care coordinator position. Moving forward, the operations team will structure all contracts for the B1 Integrated Healthcare projects to include incentives for sign-on bonus, loan repayment and relocation reimbursement as needed. Additionally, the team is offering retention bonuses to those key B1 positions hired previous to this new approach. Upon hiring the new personnel, all teams immediately shifted to providing the new hires and new teams with the trainings required to implement the specific projects. The Region 1 team is also reviewing how to standardize the onboarding process for the B1 Care Coordinator position, allowing for the local customization as needed. In fact, Region 1 IDN is sharing these onboarding processes with other IDNs as requested.

Additionally, IDN 1 supported partners' strategies to expand workforce capacity through the release of the Workforce Fund Request for Application Phase 1 in mid-February. Through direct input and guidance from

the Region 1 IDN Workforce Workgroup, the team issued a RFA allowing any partner to apply for incentive funds to support individual organizations' strategies around Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, Peer Recovery Support and Organization Capacity Support for Internships. The RFA incorporated pre-determined monetary buckets for each category; the amounts within each bracketed were based on the feedback from partners on identified needs and what felt reasonable or sustainable to partners. Due to the funding uncertainties and the need to keep current required projects fully funded, the Region 1 Executive Committee approved the release of only 50% of the approved workforce budget within each of the above-mentioned categories. The RFA was intentionally concise with a quick turnaround for submission of one month. Region 1 received seven applications of which six were almost fully funded. The seventh applicant requested over \$60K to support a certified peer recovery program. While both the operations team and the Executive Committee fully support this training program and recognize the need in the specific community and entire IDN, the organization had evolved quickly over the past year without a strong management infrastructure and the current executive director had submitted her resignation effective June 30th. Thus, the Executive Committee decided to delay the decision on this application until new leadership is in place. However, this prudence and stewardship, in turn, delays the expansion of certified recovery workers in the region. The funds approved for the other six applicants amounted to \$248,495 and is effective from March 1, 2018 – December 31, 2018. Organizations have already invested funds to execute strategies around recruitment, retention, training, supervision, internship and peer recovery support. Success stories including the hiring of a licensed drug and alcohol counselor in Sullivan County, as well as the securing of four interns, have started to be shared with the operations team.

Without a doubt, this RFA increased partner engagement across the IDN, especially with partners who hadn't been directly involved in a project. However, following its issuance, there was also a decline in participation in the Workforce Workgroup meetings, leading to a re-evaluation of our strategy. Clearly, the Workforce RFA responded to a need articulated by the IDN at large, and, with that input heard, the team believes partners took a step back from the meetings. Thus, the team is thinking of creative ways to re-engage the partners, including starting to meet quarterly in person with rotating meetings across the sub-regions, leveraging the meeting to conduct a desired training, limiting the topics during each meeting to directly address current workforce challenges, or addressing one or two milestones in each meeting. Recognizing that the Waiver is a demonstration project, Region 1 leadership is constantly considering ways to improve engagement and ultimately meet the needs of the partners within the requirements of the projects.

In the short-term, the Workforce Region 1 IDN chair is hoping to re-energize the Workforce Workgroup through the discussion of what should be included in the next phase of the Workforce RFA. Region 1 will be releasing another Workforce Fund RFA as soon as the funding uncertainties are resolved and the Executive Committee removes the pause on the workforce funds and community projects. Specifically, Region 1 will look to continue the funding brackets that were popular with the first RFA as well as fund workforce areas where the operations team and partners still see significant needs or gaps. However, the team also wants to foster engagement among community support agencies through specification of funding categories around transitional housing, vocational training, transportation and other identified needs. Through the leadership team's work with the counties on funding, transitional housing, vocational training and transportation have re-emerged as high priority areas for the respective communities and tangible opportunities to tie the IDN funding to the local need within in the approved workforce budgets. Once all funding is secured, the Region 1 IDN will adjust the workforce budget to allow for funding of community support areas. Additionally, these funding areas will complement current and future community projects.

Due to the decrease in engagement in workforce workgroup meetings post-release of the Workforce RFA, partners across the region were less focused on a collaborative social marketing campaign during this reporting period, despite the emphasis on leveling the recruitment field across the sub-region during the latter half of 2017. The leadership team thinks that, in reality, consolidating recruiting across three sub-regions doesn't actually make sense. Marketing efforts should be at the state or local levels. However, the team wishes to contribute to the statewide recruitment marketing strategies and continually engages with Bi-State and human resource representatives within partners to identified optimal strategies – one focus of many of Region 1's workforce meetings. The team understands that offering workforce funds individually to organizations was instrumental in fostering IDN engagement and partner satisfaction but will also explore funding sustainable approaches in the next iteration that will benefit sectors or sub-regions rather than unique organizations.

Region 1 continued during this reporting period to support all Statewide Workforce Taskforce activities, currently serving on three of the four sub-committees (will be on all four as of July 1, 2018), and attending all statewide meetings. Region 1 strongly supports any opportunity to centralize cross-IDN efforts to improve workforce capacity through the statewide objectives outlined in the implementation plan. In fact, Region 1 IDN believes the opportunity exists for the Statewide Workforce Taskforce to revisit the statewide plan to review appropriateness and effectiveness now that one year has passed, to take a step back and see where further centralization across IDNs would gain efficiencies. As always, Region 1 will continue to align its regional efforts with the statewide efforts and pooling resources where appropriate to enhance the overall value in addressing the behavioral health workforce challenges.

Education and Training

The Region 1 Medical Director continued to participate intently in the Education and Training Subcommittee of the Statewide Workforce Taskforce, working to align Region 1 activities with statewide activities to avoid redundancy and conserve resources in this area. He has attended numerous meetings, symposia and conferences throughout the state, and networked with the relevant organizations in behavioral health and substance use disorders. These activities and organizations include, but are not limited to the following:

- Community Health Institute/JSI Research and Training Institute (CHI/JSI)
- Youth SBIRT Initiative of the Center for Excellence
- MAT Community of Practice
- Bureau of Drug and Alcohol Services (BDAS)
- New Hampshire Foundation for Healthy Communities
- New Hampshire Charitable Foundation
- New Hampshire Citizens Health Initiative Practice Transformation Network
- American Academy of Addiction Psychiatry
- New Hampshire Alcohol & Drug Abuse Counselors Association (NHADAC)
- New Hampshire Providers Association
- Regional Node of the CTN
- Center for Technology in Behavioral Health
- New Hampshire Harm Reduction Coalition
- New Hampshire Area Health Education Center (AHEC)
- Maine Quality Counts
- Dartmouth Primary Care CO-OP

- D-H Substance Use Mental Health Initiative (SUMHI)
- New Hampshire Medical Society
- New Hampshire Academy of Family Practice
- Geisel School of Medicine Addiction and Pain Curriculum Committee

The goal is to acquire a deep understanding of the available resources and make connections between Region 1 partners and these trainings and resources.

This networking is continuous throughout each reporting period, and discussions with Region 1 partners are ongoing regarding their training needs. Region 1 is addressing most of the requested trainings relevant to the 1115 Waiver which included best practices for integrated care, certified recovery support workers, smoking cessation, alternative payment models, MAT, and SBIRT. For additionally requested trainings such as vocational training, combatting bullying or in-depth training for autism in adults, the Region 1 team continues to explore opportunities to meet these needs at the Statewide Taskforce and locally.

Region 1's Medical Director and CHI/JSI have completed the development of an Addiction 101/MAT "roadshow" and are in the process of rolling it out to primary care practices. [REDACTED]

Region 1 has actively participated in the Education and Training Statewide Subcommittee's meetings focused on determining which organizations will take responsibility for maintaining an education and training calendar, as well as an updated resource list of institutional resources and speakers on relevant topics. IDN 1 committed to helping to fund AHEC's behavioral healthcare career catalog along with the other IDNs. Clearly, the AHECs are key to efforts to promote behavioral health careers among middle and high school students and college students. In discussion with them, Region 1 identified existing programs it will be accessing and evaluating their potential in meeting the relevant workforce goals. Additionally, IDN 1 sees the need to collaborate with all of the IDNs in engaging with the AHECs to meet the collective statewide goals.

Region 1 has continued its ongoing discussions with the Center for Technology in Behavioral Health regarding their resources for training and treatment. Additionally, Region 1 has participated in the Statewide Retention and Sustainability Sub-Committee discussions around the opportunities and cost to employing tele-psychiatry; the committee is early in these discussions. IDN 1 has also joined the Recruitment & Hiring of the Statewide Workforce Taskforce.

The Medical Director has determined that adequate existing capacity exists for Recovery Coach training through NHADACA, and we intend to commit IDN dollars to support regional partners in this initiative. However, more infrastructure needs to be developed in practices for utilizing coaches before significant investment in Recovery coach training. Additionally, IDN 1 did hope to support a certified recovery coach training program through its Workforce RFA; however, the applicant is experiencing a leadership change and the financial stewardship was not in place to approve the funding. However, the Executive Committee has placed these dollars on hold while the leadership transition is finalized.

During this last reporting period, Region 1 IDN has continued to refine its strategy to meet all of the training needs of its partners including required project trainings and requested or optional trainings. Region 1 has also proactively partnered with other regions to leverage monetary resources to bring group trainings to the IDNS and to centralize training opportunities. Communication occurs regularly among our IDNs to discuss additional opportunities to share training resources. IDN 1's Medical Director (also chair of Workforce Workgroup) and Executive Director redirected time allocated for solidifying the training strategy to support the Commissioner's county strategy for returning IDN funds. As Region 1 sits in five counties, this time commitment in May and June (and continuing into July and August) turned out to be substantial. Thus, the finalized training strategy will be completed in the next reporting period. The goal of this strategy will be to meet the current needs but also create a sustainable path by utilizing dollars to support "grow your own" and "train the trainer" strategies throughout the region. Additionally, the team intends to develop a monthly schedule of required trainings and refreshers (IDN 1 is cognizant of creating access to in-person trainings across each sub-region) as well as set aside a definitive amount of money to support one-off trainings offered throughout the state. For example, IDN 1 will fund up to five or ten partners to attend existing trainings such as the NH Behavioral Health Summit. Despite the delay in finalizing the training strategy, Region 1 still offered several trainings from January through June as well as spent time planning upcoming trainings. One of Region 1's critical strategies is to record every training, disseminate via email to all partners and to post the audios and supporting documentation on the website (see below screen shots). This ensures widespread accessibility to all of the required and optional trainings.

Region 1 IDN offered over 450 training slots and ultimately sponsored or sent partners to the following trainings from January to June 2017:

Training	Month	Required	# of People Trained	# of Participating Partner Orgs	Audio/Materials Available on Website	Financially Sponsored/ Supported by IDN 1
Case Western Dual Diagnosis Program Leader Training	January		2	1	No	No
B1 Social Determinants of Health Screening Training Knowledge Exchange WebEx	January		Available to all partners	Available to all partner orgs	Yes	Yes
Behavioral Health Recruitment & Retention Strategies Training	February		Available to all partners	Available to all partner orgs	Yes	Yes
B1 Required Diabetes Training Knowledge Exchange WebEx	March	Yes	Available to all partners	Available to all partner orgs	Yes	Yes
Critical Time Intervention Training	March	Yes	4	3	No	Yes
Mental Health First Aid Instructor Training	April		2	2	No	No
IDN 1 Quality & Reporting Training	April		15	10	Yes	Yes
Mental Health First Aid Training	May	Yes	25	4	No	Yes
IDN 1 Privacy, Consent & Shared Care Planning Training	May		15	10	Yes	Yes
Mental Health First Aid Training	June	Yes	30	6	No	Yes
Partners in Recovery Wellness: Reducing Stigma Training	June		18	11	Yes	Yes
Managing Chronic Diseases in Behavioral Health Patients	June	Yes	7	4	Yes	Yes

Cherokee Integrated Healthcare Training	June		38	19	Yes	Yes
B1 Required Tobacco Cessation Training	June	Yes	Available to all partners	Available to all partner orgs	Yes	Yes

This training list does not include all of the partners who attended the state-wide quarterly and monthly Learning Collaborative trainings held by Meyers & Stauffer. Additionally, Region 1 IDN staff contributed greatly to the content development and thought leadership behind several of the Learning Collaborative sessions.

The IDN1 team has also continued to provide privacy and security advisory support to all Partners to facilitate expanded information-sharing among IDN1 partners through these partner trainings.

Region 1 IDN already has the following trainings scheduled for the next reporting period:

- Changes in NH Medicaid Training
- Introduction to Motivational Interviewing Training
- Addiction 101 Training
- Advisory Council Fall Meeting
- Management of Chronic Disease in Behavioral Health Patients Training #2
- Partners in Recovery Wellness Training #2
- Two Part Motivational Interviewing Intense Training
- Cherokee Integrated Healthcare Behavioral Health Consultant Training
- NH Behavioral Health Summit Training Support
- Mental Health First Aid Training
- Mental Health Awareness Training

Region 1 disseminates all required and optional trainings as well as resources on its website (<http://region1idn.org/>). Wherever possible, IDN 1 posts both the audios and supporting materials:



Training

Required Trainings

- Knowledge Exchange Session IV- Diabetes Training
- Knowledge Exchange Session V1- B1 Required Tobacco Training
- B1 Required Training- Managing Chronic Disease in Behavioral Health Patients

Additional Trainings

- New Hampshire 8 Hour MAT Waiver Trainings
- NH Children's Behavioral Health Workforce Development Network (the Network)'s Online Trainings
- Knowledge Exchange Session I- History of Behavioral Health
- Knowledge Exchange Session II- Navigating Change Management & Preparing for Shared Care Planning
- Knowledge Exchange Session III- Social Determinants of Health Screening Tool
- SAMHSA's Peer Navigators Support People with Serious Mental Illness
- Review of Bi-State Recruitment & Retention Conference
- Health Leads' Social Needs Workshop
- May 22nd Privacy & Consent Partner Training
- Knowledge Exchange Session V- Trainings & Resources

Supporting Materials

- B1 Integrated Healthcare Required Training- Chronic Disease Management for Behavioral Health Providers_final
- B1 Integrated Healthcare Required Training- Diabetes
- B1 Integrated Healthcare Required Training- Tobacco Treatment
- Cherokee Health Systems Integrated Care Training June 14-15 2018 Final
- Disclosure of Patient Information in an Integrated Care Model_ IDN 1 Privacy Session
- FORM B- SUD Services- Authorization and Consent to Disclose Short Form...
- IDN1 Privacy and Shared Care Planning May 2018
- IDN1 Quality Reporting Training 18 April 2018
- July & August Training Opportunities
- **June 27th Reducing Stigma Training- Partners in Recovery Wellness Presentation IDN 1**
- Knowledge Exchange 052118
- Region 1 Review of Bi-State Recruitment & Retention Conference
- Shared Care Plan Guiding Principles

[region1idn.org/resource_docs/Trainings/June 27th Reducing Stigma Training - Partners in Recovery Wellness Presentation_IDN 1.pdf](https://region1idn.org/resource_docs/Trainings/June%2027th%20Reducing%20Stigma%20Training%20-%20Partners%20in%20Recovery%20Wellness%20Presentation_IDN%201.pdf)



Region 1 E-Newsletters

- November 14th E-News
- December 11th E-News
- December 29th E-News
- February 14th E-News
- March 11th E-News
- March 27th E-News
- May 3rd E-News
- June 4th E-News

Downloadable Documents

- 10 Year Mental Health Plan Update 3-20-18
- AddictionTreatment&RecoveryInAmerica
- BDAS 2018-training-schedule
- Diversion Volunteers Needed!
- IDN1 CCSA Protocol June 2018
- Quality Reporting Guidance Document v1.0
- transformation of the mental health system glied
- zero suicide announcement letter

<https://www.integration.samhsa.gov>

Resources

- 2017 Robert Wood Johnson County Health Rankings
- New Hampshire Recovery Support Services
- New Hampshire Recovery Resource Guide
- New Hampshire Drug Monitoring Initiative
- Substance Use Mental Health Initiative Website
- DHHS Quality Performance Measures
- Behavioral Health: Fixing a System in Crisis Article
- Primary Care Matters Videos
- Culture of Health Blog
- Using Data to Understand Patients More Holistically, Part I
- Using Data to Understand Patients More Holistically, Part II
- BDAS Newsletter
- SAMHSA's BHbusiness PLUS Online Classes
- **SAMHSA-HRSA CIHS' Free Consultation on Integration of BH**
- DHHS Provider Tools- Information Related to Mental and Behavioral Health, including Opioid Overdose
- DHHS Consumer Tools- Information Related to Mental and Behavioral Health, including Opioid Overdose
- Treating Tobacco Use and Dependence- Clinical Practice Guideline
- Smoking Cessation for Persons with Mental Illnesses
- American Cancer Society Freshstart Participant Guide

Region 1 Representation:

Peter Mason, MD, Medical Director, Region 1

Will Torrey, MD, Professor of Psychiatry, Vice Chair for Clinical Services, Department of Psychiatry

More details >>>

Workforce Workgroup
Date: Nov 20, 2018
Location: Webex
Start: 2:00:00PM
More details >>>

Workforce Workgroup
Date: Dec 18, 2018
Location: Webex
Start: 2:00:00PM
More details >>>

Project Documents

- 3Rnet Bistate Presentation 2017
- Bounceback Project Concord NH Presentation
- Devine Millimet- Peg O'Brien Presentation
- HSRI Mental Health Rpt 2017-12
- Keys to Writing Successful Job Posts
- NH Quality of Life Article- Recruiting
- Region 1 Review of Bi-State Recruitment & Retention Conference

Behavioral Health Workforce
Health Information Technology
Integrated Healthcare
Care Transitions
Expansion in Intensive SUD Treatments
Enhanced Care Coordination

Region1IDN|Partnership for Integrated Care|info@region1idn.org

MAEHC

File Edit View History Bookmarks Tools Help

Project A2 - Health Information Techn X

region1idn.org/projects/a2.html

UPPER VALLEY SULLIVAN COUNTY MONADNOCK REGION

REGION1IDN ABOUT PARTNERS PROJECTS RESOURCES TRAINING VIDEOS

Project A2: Health Information Technology Infrastructure to Support Integration

Develop health information technology infrastructure to support integration

This project intends 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.

Region 1 Representation:

Mary Beth Eldredge, Dartmouth-Hitchcock Medical Center

Patti Witthaus, Valley Region Healthcare

Upcoming Meetings

Project Documents

- DHHS HIT Standards Report
- Disclosure of Patient Information in an Integrated Care Model_IDN 1 Privacy Session
- FORM B - SUD Services- Authorization and Consent to Disclose Short Form...
- IDN1 Privacy and Shared Care Planning May 2018
- IDN1 Quality Reporting Training 18 April 2018
- Quality Reporting Guidance Document v1.0
- Shared Care Plan Guiding Principles

Behavioral Health Workforce
Health Information Technology
Integrated Healthcare
Care Transitions
Expansion in Intensive SUD Treatments
Enhanced Care Coordination

Videos

Region 1 IDN Project Panel Discussion

An interactive discussion of all Region 1 IDN project teams highlighting early successes, challenges and opportunities at the February 28th Winter Advisory Council Meeting.



Region 1 IDN Health Information & Technology Update

Mark Belanger, director of Region 1 HIT, provides an update at February 28th Winter Advisory Council meeting.



Recruitment and Retention

As mentioned above, Region 1 IDN's greatest success in this past reporting period centered on the release of the Workforce Fund RFA. With about \$226,500 available to partners in the designated categories of Recruitment Conferences, Loan Repayment, Sign-on Bonuses, Staff Referral Bonuses, Relocation Reimbursement, Human Resources Recruitment Strategy and Training Programs for Retention, IDN 1 helped to support partner organization's locally-tailored recruitment and retention strategies. These funding categories and associated monetary brackets were determined by IDN partners themselves. Please see below budget section for full RFA categories, available dollars and approved allocations. This RFA both excited and engaged Region 1 partners and success stories have already been shared. Region 1 saw the most traction with loan repayment, sign-on bonuses, staff referral bonuses and marketing strategies. The IDN team also identified the need to incorporate recruitment and retention monetary incentives into all B1 project budgets moving forward given the importance of the care coordinator role needed for successful implementation.

The Region 1 team continues to examine opportunities to improve recruitment and retention strategies. The February Workforce Workgroup meeting was devoted to sharing best practices and innovative recruitment techniques to human resources directors/staff from all IDN 1 partners. One HR director presented synthesized lessons learned during the December Bi-State Recruitment Conference and his own experience as a HR director at a Community Mental Health Center. This training is also available on the Region 1 website. IDN 1 is in communication with the River Valley Human Resources Association to discuss the implementation of a trailing partners program across the region and state. Again, the Workforce Workgroup is exploring strategies to leverage the IDN 1 allocated funds for recruitment and retention to create sustainable avenues to address the workforce gaps in the project plan and to enhance capacity across the three sub-regions.

The Workforce RFA also contributed to funding the pipeline for behavioral health employees by providing financial support for organizations' capacity to expand supervision and internship programs. One organization used the money to develop its LNA training program to increase the number of LNA's to support the Medicaid Population. Please see below budget section for specific details.

The IDN continues to evaluate salary and benefit standards across the Region, as well as practice cultural characteristics, which will inform efforts to retain staff. Additionally, the Workforce Workgroup engages in discussions at every meeting to explore alternative funding sources, including philanthropy, to sustain for DSRIP-funded FTEs as well as recruitment/retention strategies.

Please see attachment A1.3A for progress against all of Region 1's Workforce milestones

A1-4. IDN-level Workforce: Evaluation Project Targets

From the IDN Workforce Capacity Development Implementation Plan, use the format below to identify the progress toward targets or goals that the project has achieved.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
New BH Clinicians recruited due to enhanced supervision capabilities	Up to 6	0	2	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Participants in the annual job fair, expressing interest in Regional BH positions	Up to 50	To be held in Spring; collaboration with other IDNs through Statewide plan.	Region 1 IDN Workforce Workgroup didn't wish to hold a Region 1 IDN specific job fair. Partners struggle with the effectiveness of job fairs in general, attending only out of obligation and the ROI may result in one new applicant. The group recommended leveraging existing job fairs, communicating existing job fairs, exploring an all – IDN virtual job fair and participating in a statewide job fair if hosted.	
Hits on the Website	Up to 100	0 hits on Region 1 IDN related to job search; Project positions were posted on specific organization's websites.	Region 1 IDN Workforce Workgroup didn't wish to post organization job postings on website; instead Region 1 IDN has measured hits on Region 1 IDN website. The team specifically is driving partners to the training and resources pages. Total Hits: Jan: 3941 Feb: 4097 Mar: 3639 Apr: 4919 May: 4450 Jun: 5899 Total Visits: Jan: 784 Feb: 809 Mar: 887 Apr: 1384 May: 1397 Jun: 1533	
Interviews with "Trailing Partners"	Up to 10	3	3: Still waiting on response from River Valley Human Resources Association to present at meeting	
Applications for Loan Repayment	Up to 20	0	4	
Culture Change/Integration education sessions	4	3	0	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Community forums held to celebrate progress in mental health/SUD care	2	To be held in Spring; collaboration with the other IDNs through Statewide plan	Partners represented on the Region 1 IDN Workforce Workgroup determined that IDN-sponsored community forums would be redundant and a poor use of resources. The group recommends leveraging and supporting existing community forums to celebrate progress in mental health/SUD. Additionally, the group believes that this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan.	
Educational institutions engaged in the workforce expansion project	3	3	3	
Meetings with IDN's and AHECs on statewide strategies	2	3	5	
Collaborative practice curriculum for students implemented at professional schools	Up to 4	1	1: This work is taking place by a team at UNH led by Joanne Malloy	

A1-5. IDN-level Workforce: Staffing Targets

From the IDN-level Workforce Capacity Development Implementation Plan, use the format below to provide the IDN's current number of full-time equivalent (FTE) staff needed to address the gaps identified in the IDN's Workforce Capacity Development Implementation Plan and the number of staff hired and trained by the date indicated. Include workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare and the IDN selected community-driven projects.

Region 1 IDN implemented a decentralized approach to hiring for the IDN projects. Thus, the Region 1 team supported its partner organizations in the necessary recruitment and hiring efforts to staff projects during this past reporting period. Region 1 succeeded in fully staffing all of its current projects though the E5 Enhanced Care Coordination project in Sullivan County was restructured and currently requires a part-time contracted facilitator (explained below). Understanding the need to differentiate the IDN project position postings, IDN 1 has incorporated recruitment incentive dollars into each B1 Integrated Healthcare project-based position. Simultaneously, Region 1 IDN released the Workforce Fund RFA Phase I to address general gaps across our region for behavioral health workforce needs, including MLADCs, psychiatrists and peer recovery coaches. The team continues to address these workforce gaps through funding organizations' recruitment, retention, and education and training strategies at both a state and regional level. Some IDN 1 partners have leveraged the funds released through the Workforce RFA to recruit MLADCs, peer recovery coaches, and interns to be placed within our most vulnerable communities. Significant recovery coach training dollars have not been committed because there needs to be more infrastructure developed in practices for utilizing coaches. However, the IDN does engage with the recovery coach programs in the region that operate on non-IDN funding. Additionally, as the projects progress, and new practices and workflows increase team caseloads in provider organizations, the Operations team will revisit the FTEs needed to meet those needs and enhance capacity. Region 1 IDN is already identifying where opportunities exist to centralize resources across sub-regions as project teams mature and efficiencies are gained; the team constantly looks to the avenues of sustainability.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Master Licensed Alcohol and Drug Counselors	Up to 8	0	0	*Workforce Funds contributed to the recruitment of 1 MLADC	
Behavioral Health Care Coordinators	Up to 6	0	5 (B1/C1/E5)	6	

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Psychiatrists	Up to 4	1 *Indicates shift in current staff time to support IDN project implementation	.3 (D3)	.3 (D3)	
Psychiatric APRN's	Up to 2	0	0	0	
Clinical Psychologists/Neuropsychologists	Up to 4	0	0	0	
Licensed Community Mental Health Counselors and/or Licensed Social Workers	Up to 6	1	1.5 (D3)	2.5 (D3, B1)	
Peer Recovery Coaches	Up to 10	0	.5 (D3)	.5 (D3)	
AmeriCorps- Community Mental Health Workers	6	* Service Year begins in October, 2017	0	3	

A1-5: Current Community Project Pilot Staffing

- The D3: PATP – IOP team is fully staffed as projected.
- The C1/E5: Co-Pilot team is fully staffed as projected.
- E5 Update: Due to the challenges shared in the last semi-annual report, IDN 1 restructured the E5 project to reside within the IDN for the short-term. Region 1 IDN contracted with a facilitator to run the existing Sullivan County All-Partner meeting which will now serve as the platform for the Coordinated Entry project. As the group matures with the new responsibility of reviewing patient cases and processes are solidified, IDN 1 anticipates that one of the community organizations will take over the ownership of the project. However, in the short-term, retaining ownership within the IDN provided the infrastructure required to gain early successes.

Project Code	Provider Type	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
D3	Masters Level clinician (BH)	1.5 FTE	Recruit to Hire	1.5 FTE	1.5 FTE	1.5 FTE
	Psychiatry (MD, ARNP)	.3 FTE	Recruit to Hire	.3 FTE	.3 FTE	.3 FTE
	OB/GYN(ARNP, CNM)	.1 FTE	Recruit to Hire	.1 FTE	.1 FTE	.1 FTE
	Pediatrician (MD, ARNP)	.1 FTE	Recruit to Hire	.1 FTE	.1 FTE	.1 FTE
	Social Work Case Manager	.5 FTE	Recruit to Hire	.5 FTE	.5 FTE	.5 FTE
	Recovery Coach	.5 FTE	Recruit to Hire	.5 FTE	.5 FTE	.5 FTE
	Childcare Providers	.75 FTE	Recruit to Hire	.75 FTE	.75 FTE	.75 FTE
	Administrative Support Staff	.5 FTE	Hired, Utilizing Current Staff	.5 FTE	.5 FTE	.5 FTE
	Certified Medical Assistant	.5 FTE	Hired, Utilizing Current Staff	.5 FTE	.5 FTE	.5 FTE
C1	Care Transition Coordinator	2 FTE	0- In process to Recruit to hire	2 FTE	2 FTE	2 FTE
	Enhanced Care Coordinators	2 FTE	0- In process to Recruit to hire	2 FTE	2 FTE	2 FTE
	Supervisor	1 FTE	In process to reallocate Current Staff % FTE	1 FTE	1 FTE	1 FTE
E5	Community Case Manager	1 FTE	Recruit to Hire	0 FTE*	1 FTE	1 FTE
	Supervisor	.1FTE	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated

A1-6. IDN-level Workforce: Building Capacity Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the workforce capacity development implementation plan which must include financial reporting on actual spending to recruit, hire, train, and retain the workforce.

Region 1 issued phase one of a Workforce RFA in February to release funds to support partner strategies around Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, Peer Recovery Support and Partner Capacity Support. The categories and associated dollars were determined in December of 2017 with clear guidance based on an all-partner workforce discussion in November and subsequent Workforce Workgroup meeting in December. Due to the funding uncertainties first delineated [REDACTED], the Region 1 IDN Executive Committee released only 50% of its allocated dollars in each of these areas in order to ensure all current projects could be fully funded should additional funding be stopped or limited.

The Workforce RFA released \$401,500 included the following funding opportunities:

Category	Sub-Category	RFA Round 1 Available Funds	Funding Brackets
Recruitment & Retention			
	Behavioral Health Workforce Recruitment & Retention Conferences	\$1500	<ul style="list-style-type: none"> • 10 awards @ \$150
	Loan Repayment (support for BH positions)	\$82,500	<ul style="list-style-type: none"> • 5 awards @ \$7500 (Master's Level) • 9 awards @ \$5000 (Bachelor's Level)
	Entry Level Position Support	\$137,500	<ul style="list-style-type: none"> • Sign-on Bonuses: 15 awards @ \$5000 • Staff Referral Bonuses: 15 awards @ \$1500 • Relocation Reimbursement: 10 awards @ \$3000 • HR Recruitment Strategy Support: 10 awards @ \$1000
	Training programs for Retention	\$5000	<ul style="list-style-type: none"> • 10 awards @ \$500
Supervision Capacity			

	Supervision Support	\$62,500	<ul style="list-style-type: none"> Funds to be allocated based on identified needs in RFAs
--	---------------------	----------	---

<i>Internship Capacity</i>			
	Internship Stipend Support	\$50,000	<ul style="list-style-type: none"> 5 awards @ \$10,000
	Organizational Capacity Support for Interns	\$25,000	<ul style="list-style-type: none"> 5 awards @ \$5000
<i>Peer Recovery Support</i>			
	Peer Recovery Support	\$37,500	<ul style="list-style-type: none"> Funds to be allocated based on identified needs in RFAs

Based on the applications, Region 1 IDN Executive Committee approved \$248,485 out of the \$318,276 requested:

Redacted Table

Though approved, Region 1 set up a monitoring framework for these awards in which funds are distributed retroactively for every category except supervision and peer recovery support programming; these latter categories are paid 50% upfront and 50% upon review of quarterly progress. Region 1 operations team also approved up to \$15,000 recruitment/retention incentive funds for Valley Regional Hospital to recruit for the B1: Integrated Healthcare Project. Similarly, IDN 1 approved a \$3000 retention bonus to the care coordinator hired last reporting period for the B1 project at Dartmouth-Hitchcock's Heater Road team. Until the funding uncertainty is fully resolved, Region 1 IDN is not proposing a revised Workforce budget to its Executive Committee. Once the issues are resolved, the operations team will be looking at restructuring the budget to adapt to the priority areas that have emerged over the last two years and/or to address the gaps currently unmet, such as the workforce in community support areas.

IDN 1 continues to refine its strategy to meet all of the training needs of its partners including required project trainings and requested or optional trainings.

Trainings funded during January to July 2018:

[REDACTED]

Region 1 IDN reformatted this budget to reflect the 5 year budget’s breakout of implementation years one through four. This table shows the Year 1 Implementation budget which includes the carry-over from the capacity building period from July 1, 2016 to June 30, 2017. It also shows how much Region 1 IDN allocated over from July 1, 2016 through June 30, 2018. All but \$2750 of these dollars were allocated in Year 1 Implementation (July 1, 2017 to June 30, 2018). As mentioned above, the Executive Committee restricted the number of dollars IDN 1 could distribute until the funding uncertainties were resolved. Additionally, not all partners were ready to apply for the funds offered in the RFA, so the IDN 1 team didn’t allocate all of the funds made available by the Executive Committee. Although these dollars have been allocated, not all IDN 1 partners have submitted invoices or reports to facilitate payment, thus, the actuals reflect lower expenditures than have been allocated. Lastly, the IDN 1 team wishes to revise the Workforce Budget to accommodate emerging priority areas and adapt to the needs of the region as well as collaborative training efforts with other IDNs. However, the IDN team decided to wait until the funding issues are fully resolved before revising and refining the budget. Thus, the team anticipates these changes will be proposed in upcoming monthly reports and finalized by the next Semi-Annual Report.

Updated Budget with projections through CY 2021 below. This budget has been constructed to include all known components of IDN operations and projects to date by CY but is subject to change as more details are determined in the upcoming implementation periods:

								Totals
Expenses								
								\$763,000.00
								\$500,500.00
								\$30,000.00
								\$4,000.00
								\$350,000.00
								\$275,000.00
								\$15,000.00
								\$50,000.00
								\$225,000.00
								\$150,000.00
								\$420,000.01
								\$327,620.00
Total	\$0.00	\$17,059.00	\$12,000.00	\$539,059.28	\$1,651,775.24	\$890,226.49	\$0.00	\$3,110,120.01

A1-7. IDN-level Workforce: Table of Key Organizational and Provider Participants

Use the format below to provide an **updated list of key organizations** and providers participating in the IDN to support workforce development within the reporting period. Include and note workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community projects.

Hope for Recovery in Claremont closed due to the loss of funding from the State. TLC Family Resource Center has absorbed the program and staff; the program is now called The Center for Recovery Resources. The Center has been supported with bridge funding until the State funding comes through and will operate as one of Harbor Homes' entities. No other changes occurred during the first six months of 2018.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Alice Peck Day Memorial Hospital	Hospital Facility	A1, A2, B1
Cheshire County (includes :)	County	A1, A2
Behavioral Health Court Program (CCBHCP)	Other County Organization	A1, A2
DOC	County Corrections	A1, A2
Maplewood Nursing Home	County Nursing Facility	A1, A2
Cheshire Medical Center/DHK	Hospital Facility	A1, A2, B1, C1, E5
Child and Family Services	Non CMHC Mental Health Provider	A1, A2, B1
Community Volunteer Transportation Company (CVTC)	Community Based Organization Providing Social and Support Services	A1, A2, C1, E5
Counseling Associates	Non CMHC Mental Health Provider	A1, A2, B1
Crotched Mountain (includes :)	Community Based Organization Providing Social and Support Services	A1, A2,
Adult Residential Services	Adult Residential Services	A1, A2
A TECH Services	Assistive Technology Clinical Consultation	A1, A2
Community Care	Community Care Management	A1, A2, B1
Outpatient Services	Specialty Outpatient Clinics	A1, A2
Crotched Mountain School	Residential Treatment	A1, A2
Dartmouth-Hitchcock Primary Care-Lebanon	Primary Care Practice	A1, A2, B1
Dartmouth-Hitchcock Dept. of Psychiatry	Non CMHC Mental Health Provider	A1, A2, B1, D3
Easter Seals Farnum Center	Other Organization Type	A1, A2
Grafton County (includes :)	County	A1, A2
Senior Citizens Council	Other County Organization	A1, A2

Granite State Independent Living	Home and Community Based Care Provider	A1, A2
Greater Monadnock Public Health Network	Public Health Organization	A1, A2
Greater Sullivan County Public Health Network	Public Health Organization	A1, A2
Headrest, Inc.	Substance Use Disorder (SUD) Provider	A1, A2, B1
Home Healthcare Hospice and Community Services	Home and Community Based Care Provider	A1, A2, C1, E5
Keene Housing	Other Organization Type	A1, A2, C1, E5
Ken Jue Consulting	Other Organization Type	A1, A2
Lake Sunapee VNA	Home and Community Based Care Provider	A1, A2
Lebanon Housing Authority	Other Organization Type	A1, A2
Life Coping Inc.	Non CMHC Mental Health Provider	A1, A2
MAPS	Non CMHC Mental Health Provider	A1, A2
Mary Hitchcock Memorial Hospital	Hospital Facility	A1, A2, B1
Mascoma Community Health Center ¹	Integrated Healthcare Provider	A1, A2, B1
Mindful Balance Therapy Center PLLC	Non CMHC Mental Health Provider	A1, A2
Monadnock Area Peer Support Agency	Other Organization Type	A1, A2, C1, E5
Monadnock Center for Violence Prevention	Community Based Organization Providing Social and Support Services	A1, A2
Monadnock Collaborative	Other Organization Type	A1, A2, C1, E5
Monadnock Community Hospital	Hospital Facility	A1, A2, B1
Monadnock Family Services	Community Mental Health Center	A1, A2, B1, C1, E5
Monadnock Region System of Care	Non CMHC Mental Health Provider	A1, A2, C1, E5
NAMI New Hampshire	Non CMHC Mental Health Provider	A1, A2
New London Hospital and Medical Group Practice, Pediatric Care Center Practice, and Newport Health Center	Hospital Facility, Primary Care Practice	A1, A2, B1
Pathways of the River Valley	Home and Community Based Care Provider	A1, A2
Phoenix House	Substance Use Disorder (SUD) Provider	A1, A2, B1
Planned Parenthood of Northern New England - Claremont	Primary Care Practice	A1, A2
Planned Parenthood of Northern New England - Keene	Primary Care Practice	A1, A2
ServiceLink-Grafton County	Other Organization Type	A1, A2
ServiceLink - Monadnock	Other Organization Type	A1, A2, C1, E5

Southwestern Community Services, Inc.	Community Based Organization Providing Social and Support Services	A1, A2, C1, E5
Sullivan County (includes :)	County	A1, A2
Dept. of Corrections	County Corrections	A1, A2, E5
Maplewood Nursing Home	County Nursing Facility	A1, A2
tlc Family Resource Center (includes The Center for Recovery Resources – formally Hope for Recovery)	Home and Community Based Care Provider	A1, A2, B1, E5
Twin Pines Housing Trust	Other Organization Type	A1, A2
Upper Valley Public Health Council	Public Health Organization	A1, A2
Valley Regional Hospital	Hospital Facility	A1, A2, B1, E5
Visiting Nurse and Hospice for VT and NH	Home and Community Based Care Provider	A1, A2
West Central Behavioral Health	Community Mental Health Center	A1, A2, B1, E5



2. Please note changes to the B1 attributed organizations relates to the updated 2017 Medicaid Attribution Numbers as those organizations with less than 150 Medicaid members were moved into support roles for B1 led projects.

Project Scoring: IDN Workforce Process Milestones

DHHS will use the tool below to review and document each IDN's Workforce Project activities. Grayed areas indicate that no submission is expected for the time frame. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A1-3	IDN-level Workforce Capacity Development Implementation Plan	Narrative & Microsoft Project or similar platform	Met	Met	Met	
A1-4	Evaluation Project Targets	Table	Met	Met	Met	
A1-5	IDN-level Workforce Staffing Targets	Table	Met	Met	Met	
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet	Met	Met	Met	
A1-7	IDN Workforce Key Organizational and Provider Participants	Table	Met	Met	Met	

Project A2: IDN Health Information Technology (HIT) To Support Integration

A2-3. IDN HIT/HIE: Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan

Each IDN was required to develop implementation plans for the July submission. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables A2-4 through A2-8 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Ongoing IDN HIT Efforts:

The Region 1 administrative team and Partners continued deploying health information technology in line with the implementation plan in Q1 and Q2 of 2018. The biggest successes in this reporting period have been engagement of several new Partners in the integrated care projects and identifying a legal pathway for SUD treatment patients and their providers to participate in shared care planning. Technology rollout continues to stay [intentionally] in line with the readiness of our Partner Organizations to engage in care integration projects. The pace of implementation is slow and steady as the projects continue to get off the ground.

Here are the high points of HIT implementation January – June 2018:

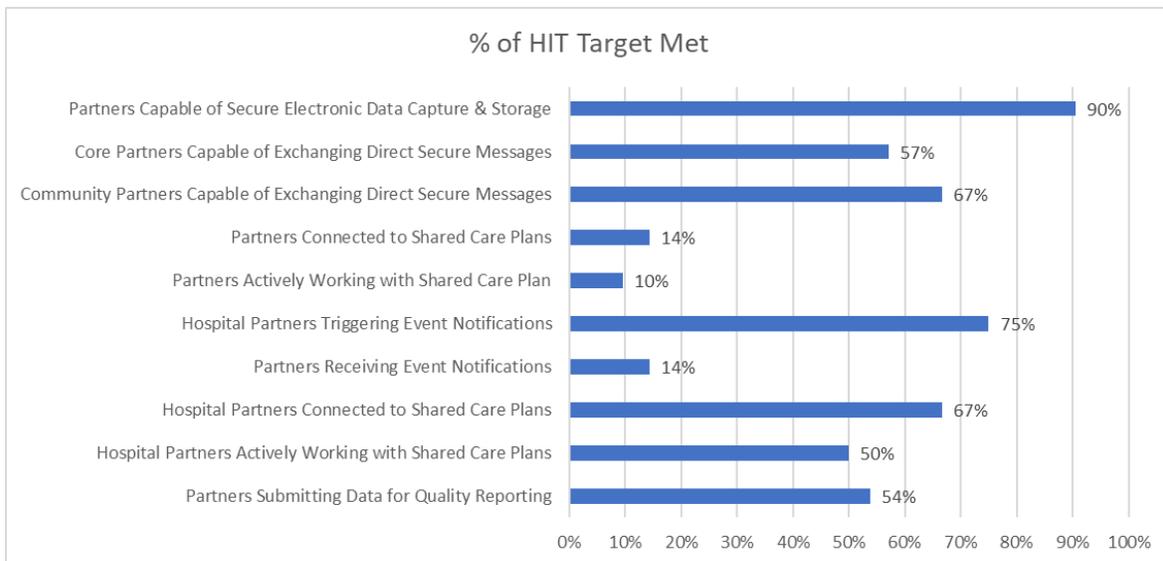
1. The team continued to support HIT deployment for our wave 1 projects. The next wave of projects has been identified, Partners have been engaged, and we have started kicking off HIT deployments with this wave now.
2. While the vendor contracting was all completed in 2017, Region 1 continued to facilitate contracting among Partner organizations and the technology vendors that require Partner level contracts (CMT, Kno2). During the SAR period the following were updated;

3. Region 1 completed protocols for the Comprehensive Core Standardized Assessment. This includes an 'out of the box' list of questions for organizations beginning from scratch with screening. It also includes a process of screening tool review and IDN-1 Medical Director approval for organizations that have existing screening practices in place. Region 1 has conducted webinars to explain to Partners the expectations for CCSA. The Protocol may be found on the IDN-1 website here:
http://region1idn.org/resource_docs/downloadable/IDN1%20CCSA%20Protocol%20June%202018.pdf
 - a. This document is also embedded into the B1 section of the SAR CCSA Section.

4. Region 1 has made tremendous progress in patient privacy. We established a new data sharing agreement that accommodates both HIPAA and 42 CFR part 2. These agreements were executed with all active projects and are in process with the new wave 2 Partners. We also identified a pathway for SUD treatment patients and their providers to participate in shared care planning. In many cases this requires modification of Partner privacy documentation and forms and we are supporting each Partner to make these changes as they begin shared care planning.
5. We continue to deploy the major technology streams with our Partners as they are ready:
 - a. Direct Secure Messaging is live with 12 Partners. Partners without sufficient EHR capabilities have deployed the Kno-2 secure mailboxes.
 - b. The event notification service and ED alerting technology, Pre-Manage ED, is live with 3 of the 6 hospitals in the region ([REDACTED]).
 - c. The shared care planning and community provider alerting technology, Pre-Manage Community, is live with three Partners.
 - d. The quality reporting platform, Massachusetts eHealth Collaborative Quality Data Center, is live with seven Partners.
6. The Region 1 Data & IT Work Group has expanded its scope to include quality improvement personnel. Three larger meetings were held in lieu of Work Group meetings in the beginning of the year: Advisory Council Meeting - All Partner Update on IT - Feb 28, Quality Reporting Session - April 18, Privacy & Consent Session - May 22. The reconstituted Data, IT, and Quality work group met monthly in May and June.
7. The IDN-1 website <http://region1idn.org/> was maintained for member communication throughout the period.

The following graph shows progress relative to targets as of the end of the semi-annual reporting period, June 30, 2018.

Figure 1: Region 1 Progress Relative to HIT Targets as of June 30, 2018



The focus of HIT implementation efforts this year has been the Core Partners of the wave 1 projects with new wave 2 projects coming online in summer/early fall of 2018. Region 1 HIT deployment is in tandem with project deployment. Each project team has defined process changes, updated patient privacy policies and processes, defined new roles to hire and train, and moved to implementation. The IT components supporting implementation are:

- Electronic Data Capture & Secured Data Storage
- Direct Secure Messaging
- Shared Care Plan
- Event Notification Service
- Quality Reporting

The deployment of the Collective Medical Pre-Manage platform for Shared Care Planning and Event Notification has been slower than planned. The deployment of the technology comes after the partner organizations are engaged, the project teams have designed and begun implementing integrated care processes, and the privacy policies and forms have been updated. IDN-1 has been focusing all energy in these areas to get the projects to the point where they are ready to bring in the shared care planning and ENS platform throughout the fall.

The following dashboard shows the HIT implementation progress to date. New for this year, the Administrative Team has identified 2 types of Partners for integration: Integrated Care Participants and Community Partners. Green indicates that the HIT capability is fully in place. Yellow indicates that contracting and implementation are in progress. Red indicates that the capability is not in place and contracting and implementation have not yet started. Measurement targets are included at the bottom.

Figure 2: HIT Dashboard – Integrated Care Partners and Community Supports

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data
Integrated Care Participants - Current						
Integrated Care Partner 1	Green	Green	Red	Red	Red	Green
Integrated Care Partner 2	Green	Green	Yellow	Red	Red	Green
Integrated Care Partner 3	Green	Green	Green	Green	Green	Green
Integrated Care Partner 4	Green	Green	Green	Green	Green	Green
Integrated Care Partner 5	Green	Yellow	Yellow	Yellow	Yellow	Yellow
Integrated Care Partner 6	Green	Green	Yellow	Red	Red	Green
Integrated Care Partner 7	Green	Green	Yellow	Red	Red	Green
Integrated Care Partner 8	Green	Yellow	Yellow	Yellow	Yellow	Green
Integrated Care Partner 9	Green	Green	Red	Red	Red	Red
Integrated Care Partner 10	Green	Red	Yellow	Red	Red	Red
Integrated Care Partner 11	Green	Green	Red	Red	Red	Red
Community Supports						
Community Supports Partner 1	Red	Red	Red	Red	Red	Red
Community Supports Partner 2	Red	Yellow	Red	Red	Red	Red
Community Supports Partner 3	Green	Green	Green	Yellow	Green	Red
Community Supports Partner 4	Yellow	Red	Red	Red	Red	Red
Community Supports Partner 5	Green	Red	Red	Red	Red	Red
Community Supports Partner 6	Green	Red	Red	Red	Red	Red
Community Supports Partner 7	Green	Red	Red	Red	Red	Red
Community Supports Partner 8	Green	Red	Red	Red	Red	Red
Community Supports Partner 9	Green	Red	Red	Red	Red	Red
Community Supports Partner 10	Green	Green	Red	Red	Red	Red
Total	19	12	3	2	3	7
Target	21	21	21	21	21	13
% of Total	90%	57%	14%	10%	14%	54%

Region 1 has simultaneously focused on engaging its hospitals to notify providers of admission, discharge, and transfer events and to receive shared care plans within the emergency departments. The following dashboard shows progress with Region 1 Hospitals.

Figure 3: HIT Dashboard - Region 1 Hospitals

Hospital	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Hospital Partner 1	Yellow	Red	Red
Hospital Partner 2	Green	Yellow	Red
Hospital Partner 3	Green	Green	Green
Hospital Partner 4	Red	Red	Red
Hospital Partner 5	Yellow	Red	Red
Hospital Partner 6	Green	Green	Yellow
Total	3	2	1
Target	4	3	2
% of Total	75%	67%	50%

Details of the HIT deployment are provided in the following sections including project plan updates and commentary.

Work Stream 1: Support Partners in Waves

The following project plan outlines the current activities, milestones, deliverables, timing, and statuses for the work stream.

Deliverable/Milestone	Jan-Jun '17	Jul '17	Aug	Sep	Oct	Nov	Dec	Jan '18	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Status	Milestone Reporting Pd	
Work Stream 1: Support Partners in Waves																					Completed	6/30/2018
Identify Partners to Support with HIT - Wave 1																					Completed	12/31/2017
Conduct RFA Process to consider, vet, and select wave 1 projects																					Completed	6/30/2017
Identify Wave 1 Core Partners and Potential Supporting Partners																					Completed	6/30/2017
Milestone: List of Core Partners and Potential Supporting Partners - Wave 1																					Completed	6/30/2017
Conduct second RFA Process to solicit additional B1 Projects																					Completed	12/31/2017
Update Wave 1 Core Partners and Potential Supporting Partners																					Completed	12/31/2017
Milestone: Updated List of Core Partners and Potential Supporting Partners - Wave 1																					Completed	12/31/2017
Identify Partners to Support with HIT - Wave 2																					Completed	6/30/2018
Conduct RFA Process to consider, vet, and select wave 2 projects																					Completed	6/30/2018
Identify Wave 2 Core Partners and Potential Supporting Partners																					Completed	6/30/2018
Milestone: List of Core Partners and Potential Supporting Partners - Wave 2																					Completed	6/30/2018
Identify Partners to Support with HIT - Future Waves																					In Progress	12/31/2018
Conduct RFA Process to consider, vet, and select future wave projects (rolling)																					In Progress	12/31/2018
Identify Wave 3 Core Partners and Potential Supporting Partners (rolling)																					In Progress	12/31/2018
Milestone: List of Core Partners and Potential Supporting Partners - Future Waves																						12/31/2018

Accomplishments:

- Region 1 has successfully vetted and selected projects for deployment wave 1 and wave 2. Deployment of HIT services has been in tandem with program deployment by the Partner organizations.

Adjustments to Plan: Project selection is now rolling with ongoing attempts to engage remaining Partner organizations.

Upcoming Activity: As Wave 2 projects progress, project leaders will engage HIT leadership to support. We anticipate project selection for remaining partners to continue on a rolling basis through the summer and into Q3 of 2018.

Work Stream 2: Engage Vendors

The following project plan outlines the current activities, milestones, deliverables, timing, and statuses for the work stream.

Work Stream 2: Engage Vendors																6/30/2018	
Complete vendor selection to support IT investments																Completed	12/31/2017
Milestone: Select vendor for Technical Support																Completed	6/30/2017
Milestone: Select vendor(s) for shared care plan, Pre-Manage ED, and ENS																Completed	6/30/2017
Milestone: Select vendor for Direct Secure Messaging Webmail																Completed	6/30/2017
Milestone: Select vendor for Data Extraction, Validation, and Quality Reporting																Completed	12/31/2017
Execute contract for Technical Support - Massachusetts eHealth Collaborative																Completed	6/30/2017
Develop contracts with Vendor and Legal																Completed	6/30/2017
Milestone: Agreement executed between MAeHC and IDN-1																Completed	6/30/2017
Execute contracts for Pre-Manage ED / ENS - Collective Medical Technology																Completed	6/30/2017
Develop contracts with Vendor and Legal																Completed	6/30/2017
Milestone: Agreement executed between CMT and IDN-1																Completed	12/31/2017
Milestone: Agreement executed between CMT and DHMC																Completed	6/30/2017
Milestone: Agreement executed between CMT and Cheshire Medical Center																Completed	12/31/2017
Milestone: Agreement executed between CMT and Valley Regional																Completed	12/31/2017
Milestone: Agreement executed between CMT and New London Hospital																In Progress	6/30/2018
Milestone: Agreement executed between CMT and Alice Peck Day																In Progress	9/30/2018
Milestone: Agreement executed between CMT and Monadnock Community Hospital																In Progress	6/30/2018
Execute end-user agreements - CMT Pre-Manage Community																	12/31/2017
Develop contracts with Vendor and Legal																Completed	6/30/2017
Facilitate agreements among CMT and Core Partners - Wave 1																Completed	12/31/2017
Cheshire Medical Center																Completed	12/31/2017
Crotched Mountain																Completed	12/31/2017
Dartmouth-Hitchcock																Completed	6/30/2017
Monadnock Collaborative																Completed	6/30/2018
Monadnock Family Services																Completed	12/31/2017
West Central Behavioral Health																Completed	12/31/2017
Valley Regional Healthcare																Completed	12/31/2017
Milestone: CMT End user agreements executed by Partners - Wave 1																Completed	12/31/2017
Facilitate agreements among CMT and Partners - Future Rolling Waves																	12/31/2018
Counseling Associates																	12/31/2018
New Hampshire Hospital																	12/31/2018
New London Hospital: Newport HC, Medical Group, Pediatric Care Practices																	12/31/2018
Milestone: CMT End user agreements executed by Partners - Future Rolling Waves																	12/31/2018

Accomplishments:

- Region 1 has executed contracts with all technology vendors including: Collective Medical Technologies (CMT) for shared care plan and event notification services, Kno2 for Direct Secure Messaging services (in cases where a Partner’s EHR is not capable of Direct), and the Massachusetts eHealth Collaborative (MAeHC) for technical support as well as data aggregation and quality reporting services.
- Contracting between the shared care plan vendor (Collective Medical) and the Direct Secure Messaging vendor (Kno-2) has been facilitated as each project is ready to support shared care planning and communications with technology.
- [REDACTED]

Adjustments to Plan: Vendor contracting with Partner organizations continues to take significant time and effort. This is due to lack of leadership attention, complex contract review, and accompanying data sharing agreements. The following wave 1 and 2 contracts are still outstanding and will be completed in the next reporting period:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Work Stream 3: Define Conventions for CCSA, Shared Care Plan, and Referrals

The following project plan outlines the current activities, milestones, deliverables, timing, and statuses for the work stream.

Work Stream 3: Define Conventions for CCSA, Shared Care Plan, and Referrals																	6/30/2018	
Define Starting Workflow Conventions with Project Teams																	12/31/2017	
Define initial CCSA Workflows with Project Teams																	Completed	12/31/2017
Define initial Shared Care Planning Workflows with Project Teams																	Completed	12/31/2017
Define initial Inter-Core Team Referral Workflows with Project Teams																	In Progress	12/31/2018
Define initial Referral to Supports Workflow with Project Teams																	In Progress	12/31/2018
Define initial Event Notification Workflows with Project Teams																	In Progress	12/31/2018
Define initial Quality Reporting Workflows with Project Teams																	Completed	12/31/2017
Milestone: Initial CCSA Workflow																	Completed	12/31/2017
Milestone: Initial Shared Care Planning Workflow																	Completed	12/31/2017
Milestone: Initial Inter-Core Team Referral Workflow																	In Progress	12/31/2018
Milestone: Initial Referral to Supports Workflow																	In Progress	12/31/2018
Milestone: Initial Event Notification Workflow																	In Progress	12/31/2018
Milestone: Initial Quality Reporting Workflow																	Completed	12/31/2017
Define CCSA Protocols																	Completed	6/30/2018
Define CCSA Protocols																	Completed	6/30/2018
Milestone: CCSA Protocol																	Completed	6/30/2018
Configure CMT - PreManage Community																	Completed	12/31/2017
Configure PreManage Community per requirements																	Completed	12/31/2017
Milestone: Initial Configuration for PreManage Community																	Completed	12/31/2017
Configure CMT - PreManage ED																	Completed	12/31/2017
Set up and tune eMPI for patient matching																	Completed	12/31/2017
Configure filtering criteria for event triggers																	Completed	12/31/2017
Configure Premanage ED Fields for ED Use																	Completed	12/31/2017
Milestone: Initial Configuration for PreManage ED																	Completed	12/31/2017
Configure Data Aggregator																	Completed	12/31/2017
Define Requirements for Comprehensive Standardized Assessment tracking																	Completed	12/31/2017
Provide Data Aggregator with DHHS measures specification																	Completed	12/31/2017
Data Aggregator to Configure Solution to Support NH 1115 requirements																	Completed	12/31/2017
Milestone: Data Aggregator configured																	Completed	12/31/2017
Debrief, Collect Learning, and Refine Workflow Conventions																	12/31/2018	
Debrief and Refine Workflow Conventions - Debrief 1																	Completed	12/31/2017
Debrief and Refine Workflow Conventions - Debrief 2																	Completed	6/30/2018
Debrief and Refine Workflow Conventions - Debrief 3																		12/31/2018

Accomplishments:

- CCSA protocols were completed and CCSA webinar /training was conducted.
- Quality reporting process continued with all reporting Participants and was rolled out with new projects.

Adjustments to Plan: Workflow conventions are still underway for Inter-Core Team referrals, referrals to supports, and event notification. These activities will slip once again to Q3 and Q4 of 2018 as they are contingent upon Partner readiness for new workflow. The CCSA Protocol milestone replaced the original milestone of creating a single CCSA.

Upcoming Activity: The priority for the next period is to replicate and scale the design work that has been completed to date and to formalize the referral and ENS workflows with the project teams. The CCSA protocol will be expanded to include adolescents.

Work Stream 4: Ensure Patient Privacy

The following project plan outlines the current activities, milestones, deliverables, timing, and statuses for the work stream.

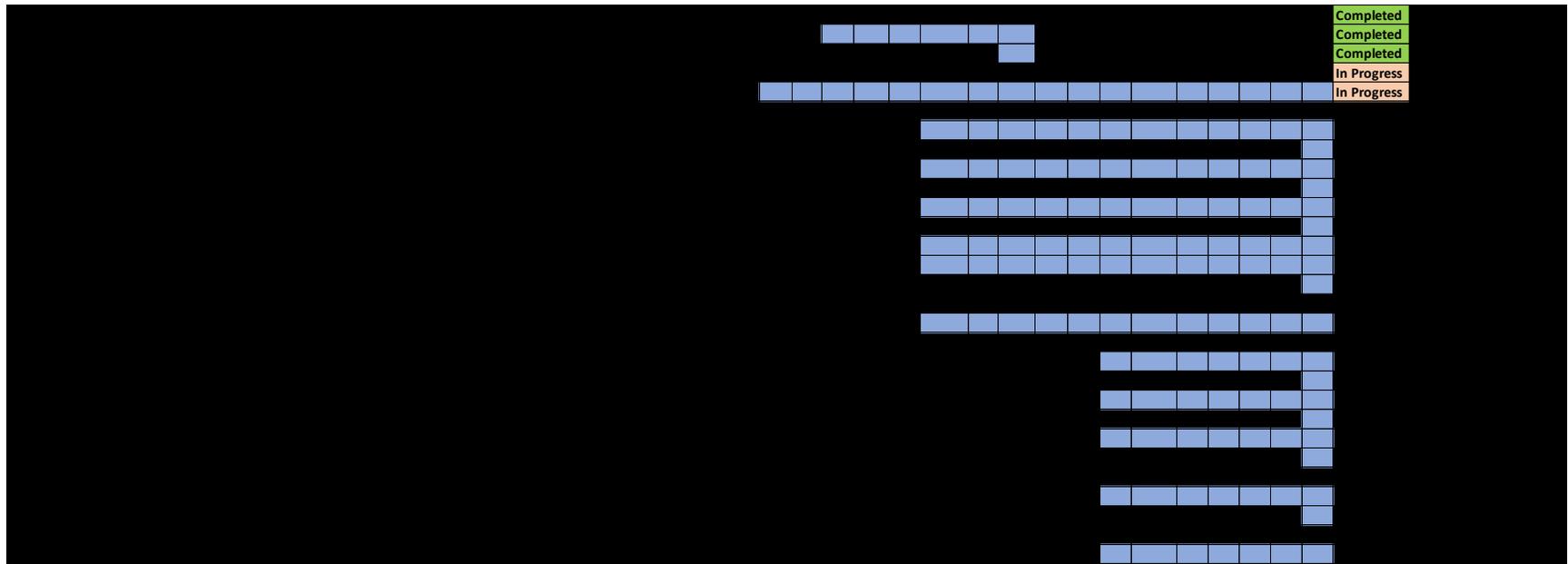
Deliverable/Milestone	Jan-Jun '17	Jul '17	Aug	Sep	Oct	Nov	Dec	Jan '18	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Status	Milestone Reporting Pd	
Work Stream 4: Ensure Patient Privacy																					Completed	6/30/2018
Attend SUD Bootcamp																					Completed	12/31/2017
Attend SUD Bootcamps																					Completed	6/30/2016
Milestone: SUD Bootcamp #1																					Completed	6/30/2016
Milestone: SUD Bootcamp #2																					Completed	6/30/2016
Milestone: SUD Bootcamp #3																					Completed	12/31/2017
Develop Foundational Patient Privacy Documents																					Completed	12/31/2017
Develop Model Content/Forms for disclosure of SUD treatment information																					Completed	12/31/2017
Milestone: Model Notice of Privacy Policy content for SUD treatment information																					Completed	12/31/2017
Milestone: Model Patient Authorization (consent) for SUD treatment information																					Completed	12/31/2017
Milestone: Model Qualified Services Organization (QSO) agreement content																					Completed	12/31/2017
Train Partners in Patient Privacy and Offer Model Forms for Partner Incorporation																					Completed	12/31/2017
Train Partners in Patient Privacy - Wave 1																					Completed	12/31/2017
Milestone: Partners Trained in Patient Privacy - Wave 1																					Completed	12/31/2017
Retrain Wave 1 Partners with new part 2 information																					Completed	6/30/2018
Train Partners in Patient Privacy - Wave 2																					In Progress	12/31/2018
Milestone: Partners Trained in Patient Privacy - Wave 2																						12/31/2018
Train Partners in Patient Privacy - Wave 3																						12/31/2018
Milestone: Partners Trained in Patient Privacy - Wave 3																						12/31/2018
Develop Standard Data Sharing Agreement for IDN-1 Partners																					Completed	3/30/2018
Deliverable: IDN-1 Data Sharing Agreement																					Completed	3/30/2018
Execute Data Sharing Agreements with Partners - Wave 1																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - Alice Peck Day																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - Cheshire Medical Center																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - Dartmouth-Hitchcock Clinic Lebanon																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - Dartmouth-Hitchcock Psychiatric Associates																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - New London Medical Group Practice																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - New London Pediatric Care Center Practice																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - Newport Health Center Practice																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - Valley Family Physicians																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - Valley Regional Hospital - Primary Care																					Completed	3/30/2018
Deliverable: Data Sharing Agreement - West Central Behavioral Health																					Completed	3/30/2018
Execute Data Sharing Agreements with Partners - Wave 2																						9/30/2018
Deliverable: Data Sharing Agreement - Counseling Associates																					In Progress	9/30/2018
Deliverable: Data Sharing Agreement - Monadnock Family Services																					In Progress	9/30/2018
Deliverable: Data Sharing Agreement - Phoenix House																					In Progress	9/30/2018
Deliverable: Data Sharing Agreement - Monadnock Community Hospital																					In Progress	9/30/2018
Confirm Patient Privacy of Vendor Systems																					Completed	12/31/2017
Define Patient Privacy Requirements																					Completed	12/31/2017
Milestone: CMT Pre-Managed Community configured/verified for Patient Privacy																					Completed	12/31/2017
Milestone: CMT Pre-Managed ED / ENS configured/verified for Patient Privacy																					Completed	12/31/2017
Milestone: Kno-2 Direct Messaging configured/verified for Patient Privacy																					Completed	12/31/2017
Milestone: Quality Reporting Service configured/verified for Patient Privacy																					Completed	12/31/2017
Define Release of Information Rules with CMT																					Completed	6/30/2018
Milestone: CMT Sensitive Information Policy (vendor responsibility)																					Completed	6/30/2018

Accomplishments:

- IDN-1 has facilitated discussions among UNH law, internal and outside counsel, Collective Medical, and DHHS to find a path forward for SUD treatment patients to be included in shared care planning and its documentation! This is one of the greatest barriers to integration overcome to date.
- Wave 1 and some Wave 2 Partners have been retrained in Patient Consent given the changes to 42 CFR part 2 in January of 2018.
- IDN-1 has engaged Hinckley Allen on behalf of Partners to offer legal advice regarding privacy protection and forms updates.
- IDN-1 guided Collective Medical as it created a sensitive information policy that is the first of their states to accommodate part 2 patients.

Adjustments to Plan: Wave 2 training is partially complete and will continue into Q3 and Q4 of 2018.

Upcoming Activity: Continue to support privacy leads from each Partner to update consent and/or authorization to release information forms. Support partner organizations as they consent SUD treatment and CMHC patients for shared care planning.



Accomplishments:

- [REDACTED] continue to automatically trigger notifications of emergency department and inpatient admissions, discharges, and transfers.

- All wave 1 Partners have received technical advisory support from the IDN and Region 1 began development of Technical Implementation Guide to support technical components of the program.
- The Shared Care Plan is live with our first group of high complexity Medicaid Members (Dartmouth Hitchcock – Heater Road Primary Care)
- Quality Reporting services deployment is underway with Partners that will be reporting for the 2018 measurement period.

Adjustments to Plan: Technology deployments continue to see major delays given difficulties with Partner engagement. This is resulting with several schedule slips.

- Shared Care Plan deployment is progressing but at a slower pace than anticipated. Deployment of Shared Care Plans will slip across all B1 Partners.
- Uptake of Direct Secure Messaging continues to lag nationally and in NH. IDN-1 is investigating alternatives to point-to-point communication including several new and innovative referral platforms for behavioral health and community supports.

Upcoming Activity:

- The Shared Care Plan is to be rolled out with each integrated care project when ready.
- [REDACTED] as well as to the community partners engaged in the projects.
- Train and support all Partners
- Formally vet alternatives to Direct Secure Messaging

Work Stream 6: Preparing for Shift to Value Based Payment

The following project plan outlines the current activities, milestones, deliverables, timing, and statuses for the work stream.

Deliverable/Milestone	Jan '19	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Jan '20	Feb	Mar	Apr	May	Jun	Status	Milestone Reporting Pd
Work Stream 6: Preparing for Shift to Value Based Payment																				
Support Planning for Shift to Value Based Payment																			Pending	6/30/2020
Inform Payment Model Discussions with HIT Expertise																			Pending	6/30/2020
Adjust HIT Service Offering to Meet Evolving VBP Requirements																			Pending	6/30/2020
Provide Ongoing Support to Partners																			Pending	6/30/2020
Provide Ongoing Technology Coordination Support to Partners																			Pending	6/30/2020
Coordinate with Vendor technical support teams to support partners																			Pending	6/30/2020
Assess HIT Technical Supports Needs																			Pending	3/30/2019
Assess HIT Technical Supports relative to Project Requirements																			Pending	3/30/2019
Assess Desired and Optional Requirements Market Readiness																			Pending	3/30/2019
Assess New Requirements Stemming from VBP Discussions																			Pending	3/30/2019
Adjust HIT Service Offering																			Pending	6/30/2020
Adjust HIT Service Offering																			Pending	6/30/2020
Provide Technical Assistance based on HIT Service Offering																			Pending	6/30/2020
Work with MCOs to Maximize Value of Data Assets for Medicaid Members (optional)																			Pending	6/30/2020
Determine role of MCO in IDN Work																			Pending	6/30/2020
Determine MCO data assets that may benefit IDN																			Pending	6/30/2020
Determine Means for Sharing Information among MCOs and IDN																			Pending	6/30/2020

Accomplishments:

- The IDN-1 Data, IT, and Quality Workgroup has begun to discuss quality reporting as a stepping stone to Alternative Payment Models.

Adjustments to Plan: No adjustments.

Upcoming Activity: HIT leadership will continue to track payment discussions and will engage

Note: Workstream 6 is anticipated to begin in 2019 and is reliant upon statewide guidance regarding the APM roadmap and related discussions and plans.

Work Stream 7: Oversee Data & IT with Governance

The following project plan outlines the current activities, milestones, deliverables, timing, and statuses for the work stream.

Deliverable/Milestone	Jan-Jun '17	Jul '17	Aug	Sep	Oct	Nov	Dec	Jan '18	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Status	Milestone Reporting Pd	
Work Stream 7: Oversee Data & IT with Governance																						6/30/2018
Support Frequent Meetings of the IDN-1 Data & IT Workgroup																						12/31/2018
Milestone: Data & IT Work Group Meeting(s) - Jan - June 2017																					Completed	6/30/2017
Milestone: Data & IT Work Group Meeting(s) - July 2017																					Completed	12/31/2017
Milestone: Data & IT Work Group Meeting(s) - Aug 2017																					Completed	12/31/2017
Milestone: Data & IT Work Group Meeting(s) - Sep 2017																					Completed	12/31/2017
Milestone: Data & IT Work Group Meeting(s) - Oct 2017																					Completed	12/31/2017
Milestone: Data & IT Work Group Meeting(s) - Nov 2017																					Completed	12/31/2017
Milestone: Data & IT Work Group Meeting(s) - Dec 2017																					Completed	12/31/2017
Milestone: CCSA Screening Protocols Sessions (2) - Feb 6																					Completed	3/31/2018
Milestone: Advisory Council Meeting - All Partner Update on IT - Feb 28																					Completed	3/31/2018
Milestone: Quality Reporting Session - April 18																					Completed	6/30/2018
Milestone: Privacy & Consent Session - May 22																					Completed	6/30/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - May 2018																					Completed	6/30/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - Jun 2018																					Completed	6/30/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - Jul 2018																					Completed	12/31/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - Aug 2018																						9/30/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - Sep 2018																						12/31/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - Oct 2018																						12/31/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - Nov 2018																						12/31/2018
Milestone: Data, IT, and Quality Work Group Meeting(s) - Dec 2018																						12/31/2018

Accomplishments:

- After regular meetings were halted to focus on onetime events such as the quality reporting and privacy summits, the Region 1 Data & IT Work Group relaunched as the “IDN-1 Data, IT, and Quality Workgroup.”
- IDN-1 put significant effort into identifying new participants for the workgroup, and in particular, in identifying quality leads from each partner organization to engage. The Workgroup is once again meeting monthly.
- The IDN-1 website <http://region1idn.org/> was maintained for member communication throughout the period.

Adjustments to Plan: No Adjustments.

Upcoming Activity: The Data & IT Work Group will continue to meet monthly.

A2-4. IDN HIT: Evaluation Project Targets

From the IDN HIT Implementation Plan, use the format below to identify the progress toward targets, or goals, that the plan has achieved.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Partners Connected to Shared Care Plans	21	2	3	
# Partners Actively Working with Shared Care Plans	21	0	2	
# Partners Receiving Event Notifications	21	0	3	
# of Partners Submitting Data for Quality Reporting (data feed and/or portal)	12	0	7	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of Project B1 Partners Capable of exchanging Direct Messages	21	13	12	
# of Community Partners Capable of exchanging Direct Messages	9	6	6	
# Hospital Partners Sending ADT Messages to ENS	4	3	3	
# Hospital Partners Connected to Pre-Manage ED	3	1	2	
# Hospital Partners Actively Working with Pre-Manage ED	2	0	1	

Note: As part of the June 2018 Semi-Annual Report submission IDN-1 has adjusted the target number of organizations to submit quality data from 12 to 13. Here is the list of organizations on which IDN-1 is focusing quality reporting deployment efforts:

1. Alice Peck Day Primary Care
2. Cheshire Medical Center (DH Keene) - Primary Care
3. Dartmouth-Hitchcock Clinic Lebanon
4. Dartmouth-Hitchcock Psychiatric Associates
5. Monadnock Community Hospital - Primary Care
6. Monadnock Family Services
7. New London Medical Group Practice
8. New London Pediatric Care Center Practice
9. Newport Health Center Practice
10. Valley Regional Hospital - Primary Care
11. Valley Family Physicians
12. West Central Behavioral Health
13. Phoenix House (added in Jan-Jun 2018 reporting period)

A2-5. IDN HIT: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Data & IT Workgroup Co-Chair (Volunteer)	.10 FTE	.1 FTE	.1 FTE	.1 FTE	
Data & IT Workgroup Co-Chair (Volunteer)	.05 FTE	.05 FTE	.05 FTE	.05 FTE	
Director of Data & IT (IDN Contracted)	.85 FTE	.85 FTE	.85 FTE	.85 FTE	

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Implementation Specialist (IDN Contracted)	.35 FTE	.35 FTE	.35 FTE	.35 FTE	

A2-6. IDN HIT: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the IDN HIT project which must include financial reporting.

IDN-1 is supporting its partners with both technical assistance and software system investment as described throughout this implementation plan. IDN-1 has budgeted costs in two categories: Consultants and Software.

The Consultant costs cover the following:

- Engagement of the Massachusetts eHealth Collaborative as the IDN-1 advisor and subject matter expert in health information exchange as well as the IDN-1 technical services support vendor.
- Engagement of Legal Services to support ongoing patient privacy planning.

The Software costs cover the following:

- Engagement of Kno-2 to provide webmail for Direct Secure Messaging.
- Engagement of Collective Medical Technologies (CMT) to provide the event notification service, Pre-Manage ED platform, and the Shared Care Plan platform.
- Engagement of the Massachusetts eHealth Collaborative to provide data aggregation and quality reporting services.'

Overview Budgets for IDN1 HIT:

Redacted Table

The following is a detailed HIT budget followed by the DHHS budget forms for each 6-month program period. This includes the projected continued implementation and deployment through 2020. At this time the forecast for A2 expenditures beyond 2020 has not been determined by IDN1. Updates to the predictive modeling of these project expenses will be made as IDN decision making determines.

Figure 4: IDN-1 IT Solutions Budget

Redacted Table

Figure 5: A2-6. IDN HIT Budget July-Dec 2017

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Subcategory Expenses				
2. Indirect Category Expenses				
3. Contractuals	210,894,229		210,894,229	
4. Equipment				
Capital				
Lease and Maintenance				
Financial Repatriation				
5. Supplies				
Educational				
Info				
Pharmacy				
Medical				
Office				
6. Travel				
7. Occupancy				
8. Contract Expenses				
Telephone				
Postage				
Subscription				
Audit and Legal				
Insurance				
Social Expenses				
9. Stipends	30,732,000		30,732,000	
10. Miscellaneous Reimbursements				
11. Staff Education and Training				
12. Subcontract Repatriation				
13. Other (specify details in narrative)				
TOTAL	\$ 241,377.59	\$ -	\$ 241,377.59	
Indirect As A Percentage of Direct:		0.0%		

Figure 6: A2-6. IDN HIT Budget January-June 2018

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Subcategory Expenses				
2. Indirect Category Expenses				
3. Contractuals	217,882,400		217,882,400	
4. Equipment				
Capital				
Lease and Maintenance				
Financial Repatriation				
5. Supplies				
Educational				
Info				
Pharmacy				
Medical				
Office				
6. Travel				
7. Occupancy				
8. Contract Expenses				
Telephone				
Postage				
Subscription				
Audit and Legal				
Insurance				
Social Expenses				
9. Stipends	190,732,000		190,732,000	
10. Miscellaneous Reimbursements				
11. Staff Education and Training				
12. Subcontract Repatriation				
13. Other (specify details in narrative)				
TOTAL	\$ 398,354.40	\$ -	\$ 398,354.40	
Indirect As A Percentage of Direct:		0.0%		

Figure 7: A2-6. IDN HIT Budget July-Dec 2018

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Staffing Expenses				
2. Indirect Expenses/Benefits				
3. Contingencies	226,000.00		226,000.00	
4. Equipment				
Furniture				
Equipment and Maintenance				
Purchase and Depreciation				
5. Supplies				
Educational				
Fuels				
Miscellaneous				
Medical				
Office				
6. Travel				
7. Contingency				
8. Contingent Expenses				
Telephone				
Postage				
Subscriptions				
Rent and Legal				
Insurance				
Miscellaneous				
9. Contingency	103,701.17		103,701.17	
10. Information/Communications				
11. Staff Education and Training				
12. Subcontractor/Agreements				
13. Other (specific details mandatory)				
TOTAL	\$ 338,701.17	\$ -	\$ 338,701.17	
Indirect/Fixed Expenses of Direct		0.0%		

Figure 8: A2-6. IDN HIT Budget Jan – Jun 2019

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages				
2. Fringe/benefits				
3. Consultants	894,708.70		894,708.70	
4. Equipment				
Rental				
Repair and Maintenance				
Purchase/Depreciation				
5. Supplies				
Administrative				
Lab				
Pharmacy				
Medical				
Office				
6. Travel				
7. Occupancy				
8. Consultant Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Travel Expenses				
9. Software	104,821.21		104,821.21	
10. Marketing/Communications				
11. Staff Education and Training				
12. Subcontract/Agreements				
13. Other (specific details mandatory)				
TOTAL	\$ 191,529.81	\$ -	\$ 191,529.81	
Indirect/Fixed Percentage of Direct		0.0%		

Figure 9: A2-6. IDN HIT Budget July-Dec 2019

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages				
2. Fringe/benefits				
3. Consultants	167,600.00		167,600.00	
4. Equipment				
Rental				
Repair and Maintenance				
Purchase/Depreciation				
5. Supplies				
Administrative				
Lab				
Pharmacy				
Medical				
Office				
6. Travel				
7. Occupancy				
8. Consultant Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Travel Expenses				
9. Software	108,841.46		108,841.46	
10. Marketing/Communications				
11. Staff Education and Training				
12. Subcontract/Agreements				
13. Other (specific details mandatory)				
TOTAL	\$ 176,441.46	\$ -	\$ 176,441.46	
Indirect/Fixed Percentage of Direct		0.0%		

Figure 10: A2-6. IDN HIT Budget Jan – Jun 2020

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages				
2. Employees Benefits				
3. Consultants	500,000.00		500,000.00	
4. Equipment				
Furniture				
Repair and Maintenance				
Purchased Depreciation				
5. Supplies				
Educational				
Info				
Pharmacy				
Medical				
Office				
6. Travel				
7. Occupancy				
8. Consultant Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Board Expenses				
9. Software	100,941.46		100,941.46	
10. Marketing/Communications				
11. Staff Education and Training				
12. Subcontract/Agreements				
13. Other (specific details mandatory)				
TOTAL	\$ 160,441.46	\$ -	\$ 160,441.46	
Indirect/Fix % Percent of Direct		0.0%		

Figure 11: A2-6. IDN HIT Budget July-Dec 2020

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages				
2. Employees Benefits				
3. Consultants	300,000.00		300,000.00	
4. Equipment				
Furniture				
Repair and Maintenance				
Purchased Depreciation				
5. Supplies				
Educational				
Info				
Pharmacy				
Medical				
Office				
6. Travel				
7. Occupancy				
8. Consultant Expenses				
Telephone				
Postage				
Subscriptions				
Audit and Legal				
Insurance				
Board Expenses				
9. Software	100,941.46		100,941.46	
10. Marketing/Communications				
11. Staff Education and Training				
12. Subcontract/Agreements				
13. Other (specific details mandatory)				
TOTAL	\$ 143,607.14	\$ -	\$ 143,607.14	
Indirect/Fix % Percent of Direct		0.0%		

A2-7. IDN HIT: Key Organizational and Provider Participants

Use the format below to provide an updated list of key organizations and providers participating in the IDN HIT project in the reporting period.

Organization Name	Organization Type
Alice Peck Day Memorial Hospital	Primary Care, Hospital
Child and Family Services	Community Support
Counseling Associates	Community Mental Health
Crotched Mountain	Mental Health Provider
Dartmouth Hitchcock: Cheshire Medical Center	Primary Care, Hospital
Dartmouth-Hitchcock: Mary Hitchcock, Heater Road Primary Care	Primary Care, Hospital
Dartmouth-Hitchcock: Psychiatry	Mental Health Provider
MAPS	Community Mental Health
Mindful Balance Therapy Center	Community Mental Health
Monadnock Collaborative (Service Link)	Care Management
Monadnock Community Hospital and Primary Care	Primary Care, Hospital
Monadnock Family Services	Community Mental Health Center
New Hampshire Hospital	Hospital
New London Hospital and Medical Group Practice	Hospital, Primary Care
New London Pediatric Care Center Practice	Primary Care
Newport Health Center Practice	Primary Care
Phoenix House	SUD Treatment
Planned Parenthood of Northern New England - Claremont	Primary Care
Planned Parenthood of Northern New England - Keene	Primary Care
Southwestern Community Services	Community Support
TLC Family Resource Center	Mental Health Provider
Valley Regional Hospital, Valley Family Physicians	Primary Care, Hospital
West Central Behavioral Health	Community Mental Health Center

*Note: The Administrative Team is continuing to work with PPNNE to determine their level of involvement. IDN-1 has previously advocated for PPNNE involvement in IDN-1 due to their primary care role for some Medicaid members. Yet, 2017 Medicaid claims data show that PPNNE serves very few Medicaid Members for this purpose. IDN-1 will make a decision in the next quarter to determine whether or not PPNNE will be included in our projects and associated HIT deployment.

A2-8. IDN HIT. Data Agreement

Use the format below to document the requirement of the data sharing agreement pursuant to STC 22.

Organization Name	Data Sharing Agreement Signed Y/N
Alice Peck Day Primary Care	Y
Child and Family Services	N (no active information sharing yet)
Crotched Mountain Community Care	Y
Dartmouth-Hitchcock Clinic Lebanon	Y
Dartmouth Hitchcock Keene (Cheshire Medical Center)	Y
Dartmouth-Hitchcock Psychiatry	Y
MAPS	N (no active information sharing yet)
Mindful Balance Therapy Center PLLC	N (no active information sharing yet)
Monadnock Community Hospital - Primary Care	N (no active information sharing yet)
Monadnock Family Services	Y
New London Medical Group Practice	Y
New London Pediatric Care Center Practice	Y
Newport Health Center Practice	Y
Phoenix House	N (In Process)
Planned Parenthood of Northern New England - Claremont	N (no active information sharing yet)
Planned Parenthood of Northern New England - Keene	N (no active information sharing yet)
Southwestern Community Services	N (no active information sharing yet)
TLC Family Resource Center	Y
Valley Family Physicians	Y
Valley Regional Hospital - Primary Care	Y
West Central Behavioral Health	Y

Please note the following indicates:

- No - Active Information Sharing Yet: Partner organization is not yet engaged in information sharing under IDN-1 projects.
- No - In Process: Partner has been briefed on data sharing agreement and is in process of executing the agreement within their leadership.

Project Scoring: IDN HIT Process Milestones

DHHS will use the tool below to review and document each IDN's HIT Project activities. Grayed areas indicate that no submission is expected for the time frame. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
A2-3	IDN HIT/HIE Implementation Plan and Timeline	Narrative & Spreadsheet (Microsoft Project or similar platform)	Met	Met	Met	
A2-4	Evaluation Project Targets	Table	Met	Met	Met	
A2-5	IDN HIT Workforce Staffing	Table	Met	Met	Met	
A2-6	IDN HIT Budget	Narrative and Spreadsheet	Met	Met	Met	
A2-7	IDN HIT Key Organizational and Provider Participants	Table	Met	Met	Met	
A2-8	IDN HIT Data Agreement	Table	Met	Met	Met	

Project B1: Integrated Healthcare

B1-2. IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan

See Appendix B1-2 for Excel Workplan of B1 Activities

Each IDN was required to complete a separate implementation plan for the completion of Coordinated Care and, if indicated, Integrated Care designations.

Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. Using Microsoft Project or similar platform update your project timeline that includes a timeline of milestones and targets for each of the Process Milestone requirements listed for reporting periods of Jan-June 2017; July-Dec 2017; Jan-June 2018; and July-Dec 2018. See the DSRIP STCs and the IDN Integrated Healthcare Coordinated Care Practice and Integrated Care Practice milestones for additional detail.

Include a detailed narrative. The narrative should relate to tables B1-3 through B1-10 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

The Coordinated Care Practice must include:

- *Comprehensive Core Standardized Assessment with required domains (Note: applies only to primary care, behavioral health and substance use disorder practitioners.)*
- *Use of a multi-disciplinary Core Teams*
- *Information sharing: care plans, treatment plans, case conferences*
- *Standardized workflows and protocols*

In addition to all of the requirements for the Coordinated Care Practice designation above, the Integrated Care Practice must include:

- *Medication-assisted treatment (MAT)*
- *Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or other evidence-supported model)*
- *Enhanced use of technology*

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners.

B1 RFP and Implementation Waves

Overview of the IDN1 Process:

The IDN-1 Executive Committee decided to use a request-for-applications (RFA) process to identify practices ready to examine their practice processes and to implement improvement work to improve integration (the terms RFA and RFP (request-for-proposals) are used interchangeably). All designated Primary Care and Behavioral Health practices, as captured in the Region 1 IDN attribution, will participate in the B1 project but they will participate in “waves;” cohorts of practices that “kick off” implementation at various times during the next 12 months. This approach provides time for practices to prepare for the time-consuming improvement work, discovery of best practices from initial B1 cohorts, testing interventions, and dissemination and implementation of best practices to address the gaps at each clinic.

The RFA process in use has been endorsed as the strategy with the greatest likelihood of creating lasting change in the IDN and the most fiscally responsible strategy. The RFA processes and structures were reviewed and endorsed by the Executive Committee. Wave I incorporated 3 rounds of the RFA process and brought 4 B1 organizations into project implementation.

Wave II launched in January 2018; RFP documents and processes were improved based on the experience with Wave 1. During late fall of 2017, the IDN1 admin team reviewed the existing RFP framework and submission materials. This review was prompted by the shift in process that was naturally occurring between the IDN1 admin team and the pending B1 practices. This shift was prompted by the network saturation of information about the B1 project and onboarding process paired with the direct coordination to B1 practices by the IDN administrative team. Over the course of early fall into early winter 2017 the admin team had begun a B1 listening tour to meet with practices, pending implementation, to readdress project goals and their next steps. Given this ongoing direct connection the team determined that much of what was initially being requested in the RFP was being generated in the pre-planning and proposal meetings. Based on this information, the IDN1 team released a short pilot of the new forms in Wave II in January 2018 with one round to close in March, 2018. When no applications were received from pending practices in the January- March submission period, the team again reviewed the strategy and proposal requirements. Understanding the B1 partners felt overwhelmed by their own inherent organizational challenges and initiatives, the IDN1 Operations team worked to modify the onboarding process to accommodate the local needs of the organizations. Using the shortened RFP framework, the Program Director readjusted to use RFP forms by organization type. The IDN has specific forms for Primary Care Sites, Community Mental Health Centers, Behavioral Health Practices, and Community Support Partners. By individualizing the forms, the IDN team has been able to pull together a standardized framework for the project onboarding process. This has included a restructuring and reallocation of the B1 funding, which will be covered further in B1-5. See examples of the updated forms below: (Taken from Primary Care RFP):

- Screening and Assessment of all NH Medicaid Patients seen at your organization or network of providers based on the guidelines of the Comprehensive Core Standardized Assessment (CCSA) (See Attached for the SDOH and Screening areas)
- Utilization of the Shared Care Plan (SCP) technology provided through the IDN
- IT contract with vendor CMT. This platform will be accessible to the MDCT Coordinator and other members as needed. (See attached for SCP overview)
- Report on IDN1 Data Measures and submit for all Medicaid Patients seen within the reporting timeframe to the QDC Team at MAeHC for submission (See attached for the Data Measures List)
 - The IDN1 Admin team will support you in coordinating with the QDC team

Payment for Activity Areas

- If your organization agrees to participate in the B1 project and to an implementation timeline launching not later than August, 2018 the IDN1 team can offer financial support according to the table below:
 - Funding will be tailored according to the % of Medicaid patients served by your organization
 - Below funding is based on serving ~3000 Medicaid Members per year. Adjustments are made to these funding guidelines appropriately

Primary Care Funding Guidelines:

PCP Primary Requirements	\$ Per Year for Implementation	Timeframe:	
		Years	Total
CCSA: SDOH/BH Screening	\$ 10,000	2.5	\$ 25,000
Shared Care Plan	\$ 5,000	2.5	\$ 12,500
MDCT	\$ 10,000	2.5	\$ 25,000
Reporting/Clinical Quality	\$ 10,000	2.5	\$ 25,000
IDN Participation	\$ 1,000	2.5	\$ 2,500
MAT	\$ 10,000	1	\$ 10,000
Other; Privacy/Consent Adherence	\$ -	2.5	\$ -
Total	\$ 46,000		\$ 100,000

B1 Care Coordinator Hire for Non-Hub PCP Participants

MSW or BA Level Care Coordinator (Salary plus Benefits)	██████████	█	\$	226,125
Sign-on Bonus	██████████	█	\$	3,000
Loan Repayment	██████████	█	\$	7,500
Total	\$ 100,950		\$	236,625

Purpose

The purpose of this Sub-Recipient proposal is to distribute funds* from the New Hampshire Delivery System Reform Incentive Program (DSRIP) to members of the Region 1**. These funds will be used to meet the goals of the DSRIP demonstration project***:

1. Deliver integrated physical and behavioral health care that better addresses the full range of the individual’s needs
2. Expand capacity to address emerging and ongoing behavioral health needs in an appropriate setting
3. Reduce gaps in care during transitions across care settings by improving coordination across providers and linking Medicaid beneficiaries with community supports

As of April 1, 2018 IDN1 has entered into an open submission period for WII practices that will conclude August 31, 2018. The flexibility of this open submission period has allowed the IDN team to work on Scope of Work and Proposal development with Newport Health Center, Monadnock Community Hospital, and Dartmouth-Hitchcock General Internal Medicine teams. Ongoing conversations are continuing with Alice Peck Day Memorial Hospital who will be going live with EPIC in February, 2019.

Notes:

**DSRIP funds are independent of current Medicaid patient reimbursement funds; these funds are to be used to create the infrastructure needed to implement the projects prescribed in the DSRIP demonstration project.*

***Region 1 includes the Upper Valley, Sullivan County and Monadnock Region.*

****The targeted population of the DSRIP demonstration project is only Medicaid beneficiaries.*

B1 Dartmouth-Hitchcock Heater Rd. South Practices /West Central Behavioral Health Integrated Care Project Updates (Addressing coordination between

providers, bi-directional integrated delivery, behavioral health services, alignment of care

Historical Context: The DH-Heater Rd. South/West Central Behavioral Health (DH-HRS/WCBH) team began meeting in late summer, 2017. Many of the project team members participated in the IDN1 project team B1 SOW development throughout early 2017. The team commenced with SDoH screening in fall of 2017 across 2 practice teams, S1, S2. This allowed for an early PDSA of the workflow and team needs to implement screening. Two Community Health Workers (CHW) are staffed within the Heater Rd. practice to do case management follow up for patients screening positive. In January, 2018 the teams CTC (Care Team Coordinator) was hired. With this hire the team quickly began working through Multi-Disciplinary Care Team mapping and shared care plan usage.

Current State: As of 06/30/18 the DH- Heater Rd. S. /WCBH project team has been fully staffed with 1 FTE CTC, 1 FTE CHW, and .5 BHC for the full Heater Rd. S. practice (S1, S2, S3 teams). A timeline of the semi-annual period activities is shared below:

- The DH-HRS/WCBH B1 Team continues to meet on a biweekly schedule with the support of the IDN Program Director, Medical Director and QI Coaching for facilitation and quality improvement guidance.
- The CTC enabled use of the shared care plan (SCP) in late March, 2018 for a pilot involving 4 patients. This process was supported by the team's creation of an interim SCP tool to be used pending the installment of re-disclosure language in the CMT software Shared Care Plan. See below for the interim tool used:

Shared Care Planning Tool

B1 Project: Dartmouth-Hitchcock Heater Road and West Central Behavioral Health

|

Name: _____ DOB: _____

Care Team: _____

Date of Completion: _____ Initials of Person Completing: _____

Person-Centered Goals

A Medicaid Member-defined outcome or condition to be achieved in the process of care. (e.g., alleviation of health concerns, desired/intended positive outcomes from interventions, longevity, function, symptom management, comfort, wellness, stability)

Concerns

A Medicaid Member and/or Care Team-defined interest or worry about a Member that may require attention, intervention, or management. (e.g., Homelessness, Food insecurity, Domestic Violence, Schizophrenia, Diabetes)

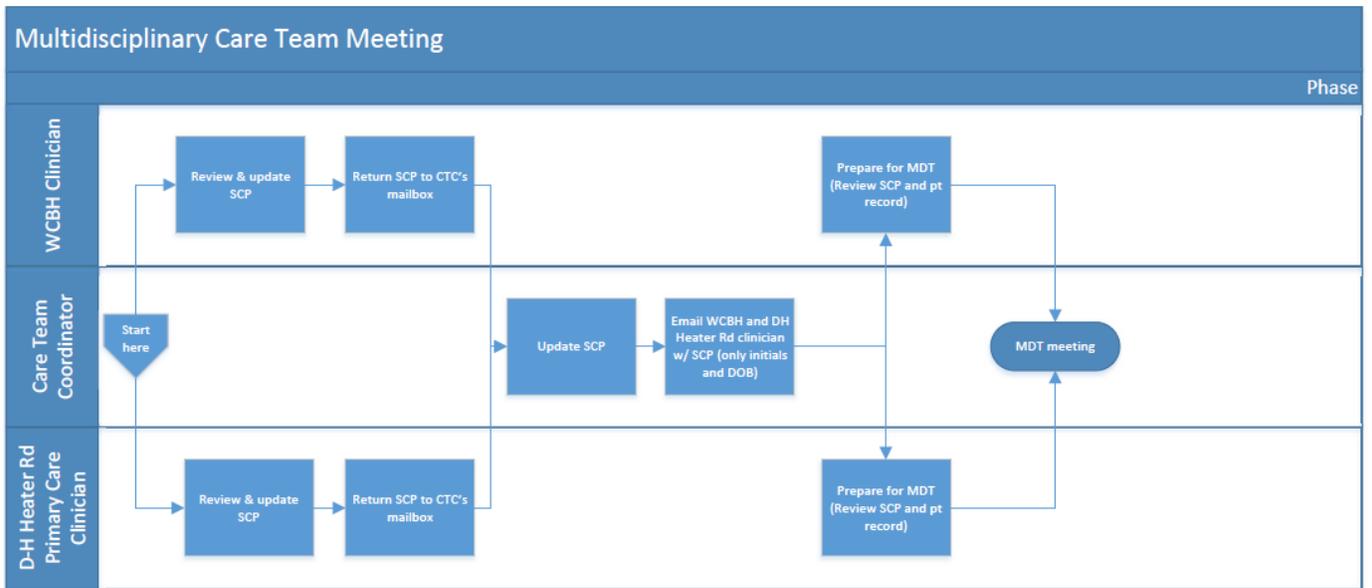
Plan

A Care Team plan for addressing Goals and Concerns. Forward looking plan that helps orchestrate actions of the Care Team and Community Support providers

Other

Use this area to document other pertinent information to the Medicaid Member that does not fall into another category

- The team targeted and met an early May, 2018 launch of the Multi-Disciplinary Care team (MDCT). This required a process flow for SCP creation and revision, DH-HRS and WCBH workflows around MDCT participation. See below:



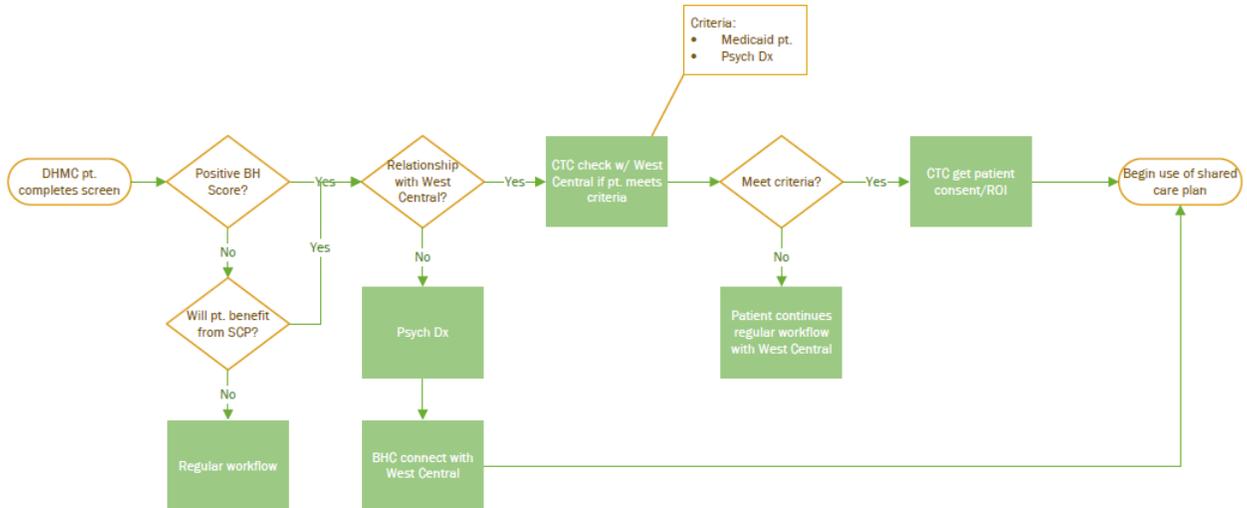
- To allow for the MDCT and SCP to proceed WCBH needed to engage with IDN1 funded legal resource for a review of their existing consent forms and a training for all of their clinician teams on the B1 project overview, review of the consent script, and introduction to the CTC.
 - The consent process required WCBH to re consent the initial 4 patient pilot pool. Using this opportunity as a PDSA the DH-HRS/WCBH team has added SCP context language to the consent process and provided the WCBH clinicians with a clear script to guide their conversation in pursuing patient consent. Example of the provider/patient consent language below:
 - “I’d like to talk to you about your Shared Care Plan. As it is a new nationwide program, we now need to obtain new consent forms to allow all of your **past, present, and future treating providers to view your care plan as needed.** (If it applies to them: **Furthermore, we do need your written permission for sharing information pertaining to your SUD treatment plan. This information requires a separate consent to use on your electronic Shared Care Plan**). At any time you may request in writing, an audit of who has viewed your Care Plan. We will check in with you to make sure your health/behavioral health goals are up to date and we can update or remove any goals that are accomplished or have changed at any time. This plan is in place to help facilitate better communication between your care teams at different facilities.”
- The CTC is located at WCBH 1 day weekly and participates in team meetings when possible. This fosters a closer coordination with the WCBH staff and inclusion in the ongoing project development.
- As of late February, 2018 the CTC supervises an AmeriCorps funded CHW, who is a person in recovery, who leads support sessions at WCBH for Medicaid patients. Additionally, the CHW attends all of the project team meetings and shares his perspective as a consumer of services. The team has found his input to be valuable and a resource to the team.
- Use of patient registry and identification fields. See example below:

Requirement	Functionality assessment	Required?	Table
<ul style="list-style-type: none"> ▪ Name 	indexed, only unique values	Yes	Demographics
<ul style="list-style-type: none"> • Date of Birth 	date selection	Yes	Demographics
<ul style="list-style-type: none"> ▪ Identification Date <ul style="list-style-type: none"> ○ date identify for program qualification 	Date selection		Demographics
<ul style="list-style-type: none"> • Date of Consent <ul style="list-style-type: none"> ○ date program begins 	Date Selection		Demographics
<ul style="list-style-type: none"> ▪ PCP name 	Free Text		Demographics
<ul style="list-style-type: none"> ▪ BH Team Leader 	Free Text		Demographics
<ul style="list-style-type: none"> ▪ Community Partners 	List of 10 or so. Multi selection <ul style="list-style-type: none"> • List to be provided 		Demographics
<ul style="list-style-type: none"> ▪ Treatment status <ul style="list-style-type: none"> ○ Identified – not active ○ Active – Monthly ○ Active - Yearly ○ Patient Opt Out ○ Inactive ○ Dropped out 	Yes – drop down list		Demographics
<ul style="list-style-type: none"> ▪ Treatment Status Comments 	Free text		
<ul style="list-style-type: none"> ▪ Date of Last MDT 	Likely possible. Need to explore to confirm.		Episodes
<ul style="list-style-type: none"> ▪ Next MDT Date 	Auto populated on a 30 day frequency with override option.		Episodes
<ul style="list-style-type: none"> • Comments/Notes 	Free Text		Episode
<ul style="list-style-type: none"> ▪ Task Name 	Free Text		Task List
<ul style="list-style-type: none"> ▪ Task Start Date 			Task List
<ul style="list-style-type: none"> ▪ Task Due Date 			Task List
<ul style="list-style-type: none"> ▪ Task Status 	Not Started In Process Complete		Task List
<ul style="list-style-type: none"> ▪ Notes 	Free Text		Task List

- Ongoing coordination with other IDN projects and external project work within DH-HRS. The CTC takes the lead on the coordination and participates in ongoing DH system wide meetings. Additionally, the use of the SCP prompts an immediate flag on the EPIC patient screen which

triggers a clinician looking at the record to see the IDN involvement. This can also be triggered by looking at the Care Team providers where the CTC is listed.

- For CCSA completion at HRS the team follows the SDoH pathway formalized in the IDN1 CCSA protocol (see sections below) and as the single encounter CCSA fields are being built into EPIC the following workflow is being used:



- For patients who receive care at DHHS and WCBH, responsibilities for completing the CCSA are shared between the two organizations. Each organization uses its own survey instrument but both instruments cover required domains.
 - The project team has seen value in coordination through the SCP in the screening identification and follow up.
- Ongoing efforts have been made to share project information to the B1 population being seen at HRS and WCBH. This effort commenced with a letter out to community support partners and has continued with the below flyer being used for patient education. See below:

Your Shared Care Plan

The diagram features two overlapping circles. The left circle is dark blue and labeled 'Primary Care Team'. The right circle is yellow and labeled 'Behavioral Health Team'. The intersection of the two circles is a lighter blue. A white line with a dot at the top and bottom extends from the top of the intersection to the title 'Your Shared Care Plan'.

Primary Care Team
D-H Heater Road
Primary Care

Behavioral Health Team
West Central
Behavioral Health

- A care plan that focuses on what's important to you!
- Improves communication between your Primary Care and Behavioral Health teams
- Your shared care plan is available to you and your providers

201805-96

- The B1 project team is contributing to Dartmouth-Hitchcock efforts to refine SDoH surveys and develop resources to address patient needs. This work includes refinements in the screening survey instruments and standardized responses to identified needs (referred to as “pathways” templates): Examples of the updated screening and pathways materials are shared below:



Q-SOCIAL DETERMINANTS OF HEALTH (SDOH)

Please answer the following questions and click the **Continue** button.

Please answer the following questions to help us better understand you and your current situation. The information you provide will be entered into your medical record and will be used by your health care team to develop a plan to help you maintain or improve your health and well-being.

Housing

What is your housing situation today?

I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

I have housing today, but I am worried about losing housing in the future. I have housing

Think about the place you live. Do you have problems with any of the following?

Select all that apply.

Bug infestation Mold Lead paint or pipes Inadequate heat Oven or stove not working

No or not working smoke detectors Water leaks None of the above

Financial Strain

How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?

Not hard at all Somewhat hard Very hard

What do you have trouble paying for?

Select all that apply.

Food Housing Utility bills (electric, etc.) Childcare Medical needs (medicines, doctor, etc) Debts

Other

Education

Do you ever need help reading hospital materials?

Yes No

Social Isolation

Do you have someone you could call if you need help?

Yes No

Transportation

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Select all that apply.

Yes, it has kept me from medical appointments or getting medications

Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need No

Employment

What was your main activity during most of the last 12 months?

Worked for pay Attended school Household duties Unemployed Permanently unable to work

Other

Legal

Do you have any legal issues that are getting in the way of your health or healthcare?

Yes No

Interpersonal Safety

In the last 12 months, are you or have you been threatened or abused physically, emotionally or sexually by a partner, spouse or family member?

Yes No

Assistance

Would you like help with any of these issues?

Yes No

- Examples of the Employment pathway below:

Employment Pathway

Initiation
Client is requesting assistance with obtaining employment.
Partner with client to identify employment goals; document goals and/or desired job.
Identify barriers to employment: <input type="checkbox"/> Discrimination <input type="checkbox"/> Criminal record <input type="checkbox"/> Financial <input type="checkbox"/> Inadequate education or skills (refer to Education Pathway) <input type="checkbox"/> Disability <input type="checkbox"/> Language (e.g. English as a second language – refer to Education Pathway) <input type="checkbox"/> Other: _____
<ul style="list-style-type: none"> - Partner with client to identify education and work history. - If need identified, refer to vocational program. - Assist client with resume development, cover letter, and/or application; document date paperwork is completed. - Work with client to identify references and discuss plan for obtaining references. - Contact employment resources and make appointment(s) as needed. - Help client prepare for appointment(s) (e.g. childcare, transportation).
<ul style="list-style-type: none"> - Confirm that client kept appointment(s) if scheduled; accompany client to appointment(s) if needed. - Confirm that client has completed applications or other paperwork as needed; assist client as needed.
Partner with client to monitor application and interview process; assist client in tracking progress.
Completion
Client has been employed consistently over a period of 3 months.

Name of organization(s) that assisted with this pathway: _____

Record Reason if Finished Incomplete: _____

Version Feb 2018
 Adapted from the Pathways Community HUB standardized pathways developed by Drs. Mark and Sarah Redding, <https://innovations.ahrq.gov/qualitytools/connecting-those-risk-care-quick-start-guide-developing-community-care-coordination>

- The project team is working to define their Year 2 milestones for quarterly review and progress tracking. The evaluation format used in Year 1 will continue with a template format and standardized submission dates. All Y2 project teams are required to determine at minimum one outcome milestone per quarter to support team buy-in to the rolling QI and evaluation process. Example of one quarter milestones below;

Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Q1 Y2: July 1, 2018-September 30, 2018						
Heater Road Practice Team: DH PC, DH Psych., WCBH	<i>Milestone 1:</i> Utilization of SCP for all indicated high acuity patients	SCP Quarterly Data				
	<i>Milestone 2:</i> Adherence to CCSA response protocol	CCSA Quarterly Data				
	<i>Milestone 3:</i> MDCT meetings held monthly (at minimum)	Meeting Calendar				
	<i>Milestone 4:</i> Clinical Data Collection and Outcomes Captured and Aligned with QR	Details of Outcomes Data				
Q2 Y2: October 1, 2018-December 31, 2018						

- As of reporting the team has completed 4 sessions of the MDCT and is continuously expanding program size. Currently there are 15 shared patients identified for SCP and MDCT utilization.

B1 Valley Regional Hospital Primary Care Practice /Counseling Associates (VRH/CA) Coordinated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care)

Historical Context: The VRH/CA B1 project was approved in Wave I and the team commenced meeting in mid-fall 2017. Due to limitations on the Primary Care clinical staff, the group elected to begin meeting with a small sub-workgroup which included the Practice Director, IDN funded contracted Project Manager, QI Coach, and IDN Program Director. The full team began meeting in a bi-weekly cycle in early winter.

Current State:

- The project team meets every week in either a full team meeting including clinical staff at both VRH and CA or with a small planning sub group that acts as a project team steering committee.
 - Meetings have been underway since January, 2018.
- In February, 2018 the project team completed a charter to guide their shared B1 implementation. See below:

1. General Project Information				
Project Name:	Behavioral Health Integration within Valley Primary Care			
Executive Sponsor:	Region 1 Executive Committee			
2. Project Team				
	Name	Organization/Department/Affiliation	Telephone	E-mail
Project Lead:	██████████	Vallery Regional Hospital		██████████
Data Lead:				
Pratice Facilitator	██████████	IHPP/UNH	██████	██████████
Project Manager	██████████	Valley Regional Hospital	██████████	██████████
Team member	██████████	Valley Regional Hospital		██████████
Team Member	██████████	Counseling Associates		██████████
Team Member	██████████	Valley Regional Hospital		Christina.bateman@vrh.org
Team Member	██████████	Valley Primary Care		██████████
Team Member	██████████	Valley Primary Care		██████████
Team Member	██████████	Valley Primary Care		██████████
Team Member	██████████	VRH Case Manager		██████████
Team Member	██████████	VRH Director of IT	██████	██████████
Team member				
IDN Data Lead	██████████	Region 1/IDN		██████████
IDN PM Lead	██████████	Region 1/IDN		██████████
IDN MD Lead	██████████	Region 1/IDN		██████████
Patient/Family Representative				

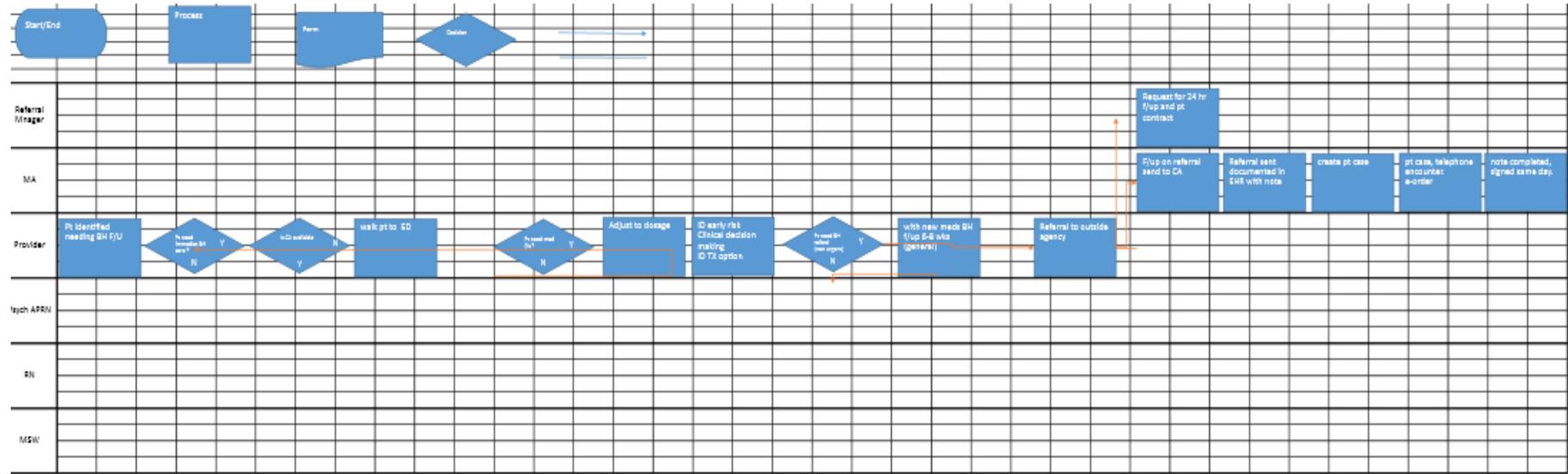
3. Stakeholders (e.g., those with a significant interest in or who will be significantly affected by this project)
VRH Department: Valley Primary Care & Valley Regional Hospital
Community Partners: ServiceLink, Lake Sunapee VNA (LSVNA), Planned Parenthood of New England (PPNE), TLC Family Resource Center (TLC), West Central Behavioral Health, No Wrong Door
Counseling Associates Patients
Valley Regional Primary Care Patients
Region 1 IDN Partners
Region 1 Executive Committee
Region 1 Administrative team
4. Project Scope Statement
Project Purpose <i>Describe the need this project addresses</i>
Over a three-year period, VRH will establish innovative and collaborative relationships with behavioral health providers and community partners; create effective and efficient procedures and workflows; and, shift traditional thinking to embrace a multi-faceted approach to mental health and primary care integration. Valley Primary Care will achieve Coordinated Care Practice Designation by December 2018.
Objectives <i>Describe the measurable outcomes of the project (e.g., reduce cost by xx, increase screening rates by yy)</i>
<ul style="list-style-type: none"> • Comprehensive Core Standardized Assessment Process • Execution of a web-based Shared Care Plan • Creation of a Multi-Disciplinary Team • Pilot an embedded telepsychiatry resource within the primary care setting to serve the identified patient population, as well as provide a resource for primary care physician consultation. • Establish (2) new FTE positions within Valley Primary Care – MSW and RN; establish a new Psych-APRN position for medication management (1) day per week • Establish a bi-directional referral system with Counseling Associates of Claremont • Provide training opportunities to enhance support services for behavior health integration at VPC, as well as partner development.
Deliverables <i>List the high-level “products” to be created (e.g. process workflow created, shared care plan developed)</i>
See Implementation Plan
Scope <i>List what the project will and will not address (e.g., this project addresses all Medicaid patients, Medicare patients are not included)</i>
<p>The Valley Regional Hospital (VRH) system provides community members with a Critical Access Hospital, three primary care outpatient centers and specialty practices in orthopedics, women’s health, oncology, urology, pulmonology, podiatry, cardiology and general surgery. With over 47,000 community members, residing across the 15 towns and 537 square-miles of Sullivan County, the rural landscape offers many challenges to accessing healthcare, be it oral, medical or behavioral health.</p> <p>Initially, the proposed VRH Behavioral Health Integration Project will focus on New Hampshire Medicaid patients, age 12 and over, receiving services within Valley Primary Care, referred to as VPC, herein. However, as the pilot progresses, with success and best practices guiding the way, VRH will expand its initiative to all VRH primary practices and all patients, regardless of payment source.</p>
Project Milestones <i>Propose start and end dates for Project Phases (e.g., Planning, Implementation) and other major milestones</i>
See Milestone Document
Measures & Outcomes <i>In this section list all objectives, measures, or outcomes including those listed in the AIM Statement.</i>
See Data and Outcomes Targets

- Given limited staffing at VPC the initial steering committee me to establish staffing needs and identified two needed positions;
 - 1 FTE MSW- Hired in May, 2018
 - 1 FTE RN- Recruit to Hire Ongoing
- To manage the staffing and project support in the interim period the team identified the following resources:

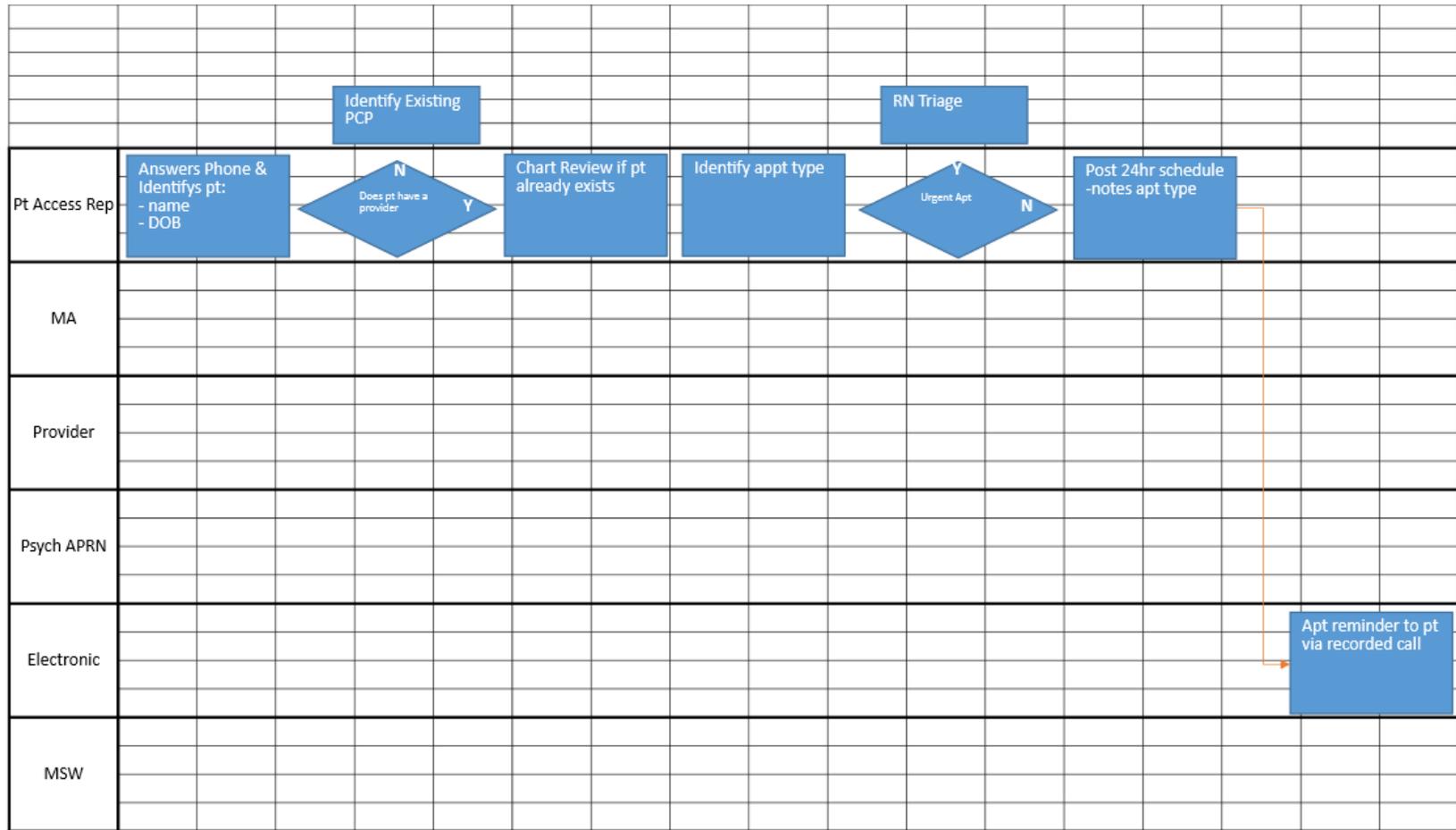
Staffing Resources	Community Partners
<p>VPC Physician Providers</p> <p>CA Mental Health Providers</p> <p>VPC ~ MSW</p> <p>VPC ~ Patient Care RN</p> <p>VRH ~ Psych APRN</p> <p>Medical Assistant</p> <p>Patient Care Representatives</p>	<p>Counseling Associates of Claremont</p> <p>DHMC ~ Dept. of Psychiatry</p> <p>Lake Sunapee Region VNA</p> <p>Planned Parenthood of NE</p> <p>ServiceLink</p> <p>TLC Family Resource Center</p> <p>West Central Behavioral Health</p>

- Given the staffing needs and current staff constraints at VPC the team began their improvement work with a review of current processes and workflows. Examples below:

Patient Identified as needing BH Services- VPC Process Map:

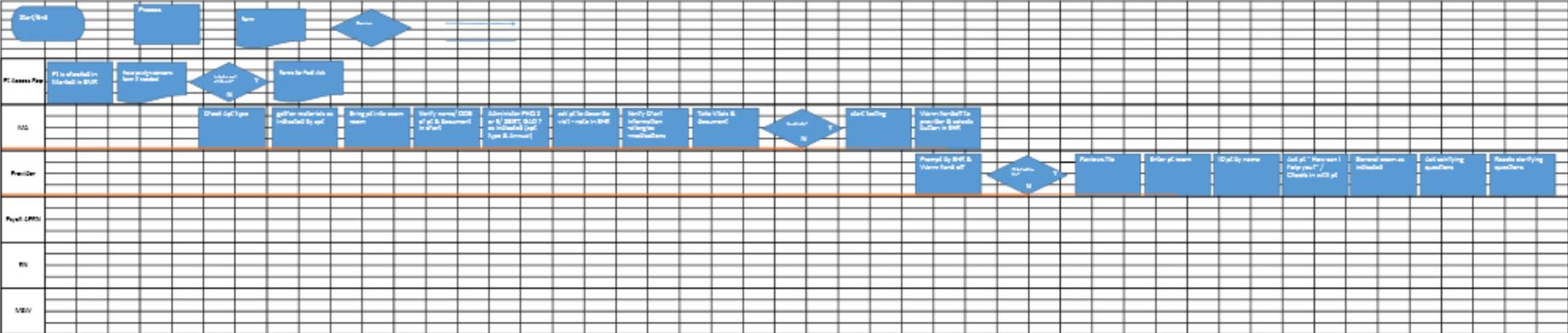


Pre- Appointment- VPC Process Map:

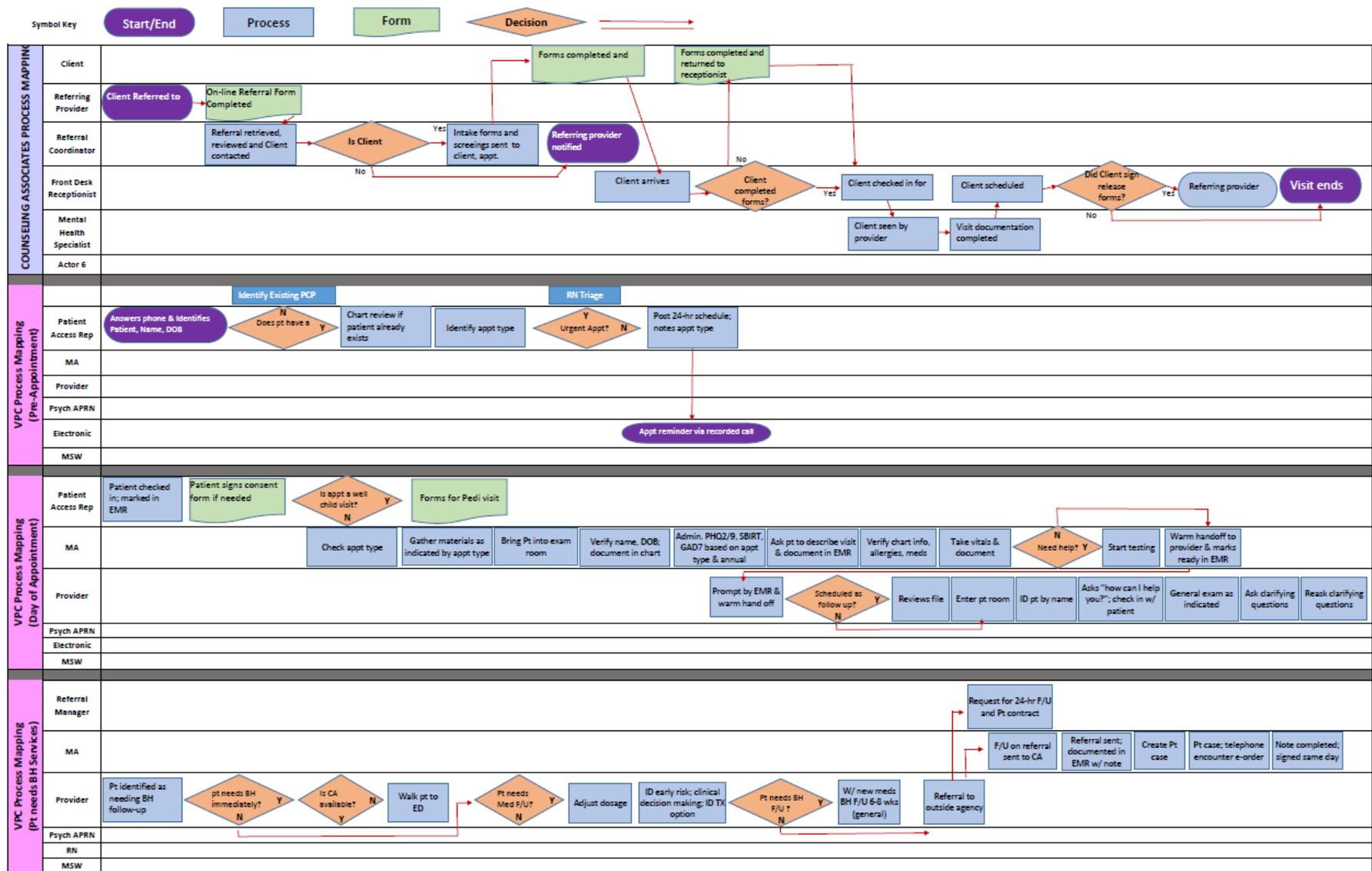


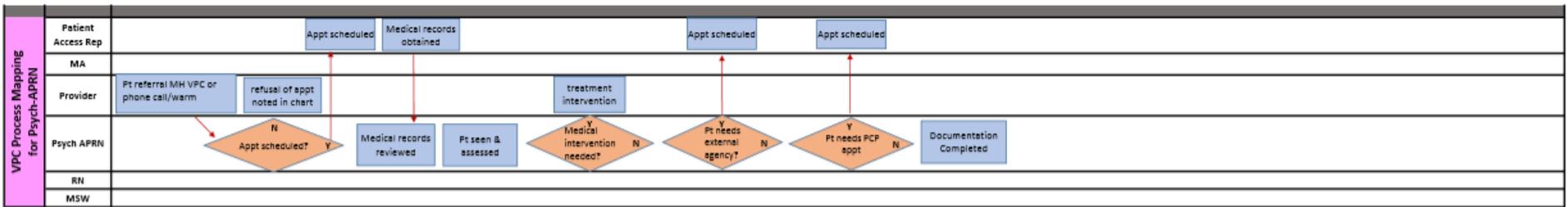
Appointment Day of- VPC Process Map:

V



VPC/CA Combined Process Mapping:





- The extensive process mapping and workflow mapping created by the team served to orient both organizations to the others processes as well as to highlight areas where process and clinical flow is needed to launch the CCSA, MDCT and utilize SCP. Additionally, refining the referral process across both sites will serve as a foundation for the expanded relationship and enable closed loop referrals.
- Given VRH’s EHR conversion in spring, 2018 the project team has spent considerable time on planning for implementation and review of the current state VPC screening processes. The team has used the IDN1 CCSA protocol and SDoH screener from the DH-HRS/WCBH as guidance in their screening process development. Deployment is planned for August, 2018.
- With the hire and onboarding of the MSW CTC the team is formalizing their planning for MDCT implementation and process.
- The project manager, practice director, physician champion and MSW CTC from VPC attended both days of the IDN1 Cherokee Health sponsored training and will look to participate in the BHC specific training in September. Numerous clinicians from Counseling Associates also attended and both groups worked together through breakout exercises on project specific development.
- The project team continues to look at opportunities for Telehealth and psych. VPC is in contract with DH for these services and looking to build from the existing work there. CA applied for IDN1 workforce funds in spring, 2018 to establish some telehealth capacity for their clients in Sullivan County.
- Additionally, the project team is exploring options to bring blood pressure testing capacity to CA for the shared B1 and Medicaid clients. The team is in communication with existing practices within NH that offer these services and looking at the feasibility of implementation and research on liability/insurance coverage.
- The team is coordinating with data and analytics staff at VPC and the partners at CA to address outcome reporting and leading team exercises in July to look at the priority areas aligning with the proposal.
- VPC is in conversation to partner directly with WCBH for BH services as well given that in the most updated 2017 data there are 410 represented shared Medicaid patients in Sullivan County between the two organizations.
- The team is following and updating their quarterly evaluation framework. See below for current milestones.

• Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Project Q1 (Grant Q3, Y1) January 1, 2018-March 30, 2018						
VRH, CA	<i>Milestone 1:</i> Demonstrate Commitment from Primary Care Pilot Team	Self-Report	Met	Met	Met	Met
	<i>Milestone 2:</i> Develop Project Team with Members from VRH, CA	Share Project Team Membership List	Met			
	<i>Milestone 3:</i> Recruit to Hire Activities for All Open Positions	Share Job Posting, Follow up	Met/Pending Hiring			
	<i>Milestone 4:</i> Complete Formal Project Agreement between VRH, CA (MOU, or other)	Share Final Document	Met			
Project Q2 (Grant Q4, Y1): April 1, 2018-June 30, 2018						
VRH, CA	<i>Milestone 1:</i> Complete Patient Flows for VRH Clinic and CA	Share Completed Mapping	Met	Met	Met	Met

<i>Milestone 2:</i> Complete Clinic Flows for All Applicable Appointment Types at VRH Clinic and CA	Share Completed Mapping	Met			
<i>Milestone 3:</i> Complete Team Charter	Share Completed Charter	Met			
<i>Milestone 4:</i> Conduct Outreach to Project Involved Community Stakeholders	Share Partner Communication	Met			
<i>Milestone 5:</i> Develop Standardized Workflows and Protocols for MDCT	Share Completed Mapping	In Process			

- Future state process mapping is underway as of June 30, 2018 and will be reported in the subsequent SAR section pending the hire of the RN position.
- Listing of Community Clinic, Behavioral, Social Services Resource Guide for the B1 Project for VRH/CA as of June, 2018. Additional supports will be added as the project pilot grows.

Primary and Specialty Providers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Valley Regional Hospital	[REDACTED]	542-7771, ext. 3449	
Valley Family Physicians	[REDACTED]	543-1251	
Valley Primary Care	[REDACTED]	542-6700	
Newport Health Center		863-4100	
Valley Regional Primary Care Physicians, Newport		863-6400	
Springfield Health & Rehab		802-885-5741	
Charlestown Family Medicine		826-5711	
Keady Family		826-3434	

Behavioral Health Providers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Counseling Associates of Claremont		865-1321	
Twin State Psychological Services		542-1877	
West Central Behavioral Health		542-2578 office 542-5128 Intake 542-2578 Elderly Srv 800-565-2578 crisis 542-5449 children	

Abuse, Domestic Violence

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Turning Points Network		543-0155 Claremont 863-4053 Newport	Domestic violence, sexual assault and stalking
WISE, 38 Bank St, Lebanon		603-448-5922	Serves VT & NH outside of Sullivan County

Infants, Children, Families

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
TLC Resource Center, 109 Pleasant St, Claremont		542-1848	
NH WIC program		542-9528	Southwestern Community Services

Substance Use Disorder

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Headrest, 14 Church Street, Lebanon		Crisis Line 603-448-4400 Business Line 603-448-4872	24 hour crisis line, low intensity residential treatment, outpatient counseling

Dental Providers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Community Dental Care of Claremont		6032871300	Provides dental care for all ages, no insurance, underinsured, or private insurance
Spence Dentistry for Children		543-0455	
Claremont Family Dentistry		542-7100	

Adult Day Programs/Senior Centers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Newport Senior Center		863-3177	
Charlestown Senior Center		826-5987	
Claremont Senior Center		543-5998	
Springfield Adult Day Services, Vermont		802-885-9881	

Housing and Rent Assisted Living

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Brookside Apts, Wilder, VT		802-295-7511	Income-determined housing; any age
Cedar Hill Assisted Living, Windsor, VT		802-674-6609	Senior living
Earl Bourdon Center, Maple Street, Claremont		542-5015	Senior living
Marion Phillips Apts, Broad St, Claremont		542-6411	
Elmwood Center, Rte 120, Claremont		Admissions 287-5005	Skilled Nursing and Rehabilitation
Hanover Terrace		667-0638	
Horseshoe Pines		863-5500	Private assisted living home
McCoy Home, Claremont		543-1255	Assisted Living
Sullivan County Nursing Home		542-9511	
Silver Maples, Winter St, Claremont		543=3628	
Sugar River Mills		542-2976	Income determined housing
Summercrest Assisted Living, Newport		863-8181	Assisted living
Woodlawn, Newport		863-1020	
Hillside Terrace, Charlestown		836-5680	

Food Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Claremont Soup Kitchen		543-3290	Food Pantry, evening meals
DCYF (Central Intake)		800-894-5533	Division of Children, Youth, Families
Newport Food Pantry		863-3411	
Southwestern Community Services			WIC program

Transportation Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
SCS Transportation		603.542.9609	
Golden Cross Ambulance	█	542-6660	Wheelchair and medical transports
Flying Aces Taxi		558-3116	
Medicaid Transportation, NHHF, Wellsense		844-259-4780	NH residents only ... State program
VT Medical Transports		802-460-1195	For Vermont residents only

Aging, Disability, Personal Care Services

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Lake Sunapee VNA, New London		800-310-4077	
Bayada		Hospice-802-526-2380 Home Care 802-254-7071	
Bureau of Adult/Elderly Services (BEAS)		603 543-4638; central intake: 603 271-7014	
DCYF (Central Intake)		800-894-5533	Division of Children, Youth, Families
Granite State Independent Living		800-826-3700	
VT Council on Aging		802-885-2655	Senior helpline
Hospice House, Concord		224-2273	
Keene Medical Care Products		448-5225	
Lifeline		800-451-0525	
Pathways of the River Valley, Claremont		542-8706	Developmental Disabilities Area Agency

Legal Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
NH Legal Assistance		800-562-3994	Legal advocacy to secure benefits, treatment, housing, utilities]
DCYF (Central Intake)	[Point person]	800-894-5533	Division of Children, Youth, Families

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Sullivan County Court		885-212-1234	

Volunteer and Faith-Based Services

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
St. Vincent de Paul, Claremont		542-9518	Financial assistance
Service Link		542-5177	Referral and resource organization
Newport Area Association of Area Churches		863-3411	Operates the Newport Food Pantry

Medical Detox Facilities

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Farnum Center, 140 Queen City Ave, Manchester, NH		888-840-4243	Resource for those with NO insurance or State insurance.
GateHouse Treatment 112 West Pearl Street Nashua, NH		855-448-3588	Accepts private insurance.
Riverbank House 96 Church Street Laconia, NH		603-759-2895	Accepts private insurance.
Phoenix House 106 Roxbury Street Keene, NH		603-358-4041	Accepts private insurance.
Hampstead Hospital 218 East Road Hampstead, NH		603-329-5311	Accepts private insurance.
New Freedom Academy 367 Shaker Road Canterbury, NH		877-852-4320	Accepts private insurance.

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Green Mountain 244 High Watch Road Effingham, NH		877-890-3234	Accepts private insurance.
Antrim House (Women Only) 55 Main Street Antrim, NH		1-855-644-3876	Accepts private insurance.
Granite Pathways		1-844-640-7277 or 603-931-3700	Granite Pathways does assessments over the phone to determine which agencies may best service clients' needs. They will assess clients over the phone to determine level of care and are also able to speak directly with treatment centers on their behalf and help clients apply for these programs.

Town/City/State Specific Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	NOTES
Claremont City Welfare		542-7007	
Lempster/Unity/Charlestown/Sunapee		863-9529	
Newport Town Welfare Asst		863-4765 x. 129	
NH Healthy Families		263-7192	
Southwestern Community Services		542-3160, 542-9528	CAP Agency for Sullivan County, fuel assist, WIC, homeless shelter
Veterans Admin Advice Line		802-295-9363	Option 4 ext 2
Cover (VT Home repairs)		802-296-7241 sarahb@coverhom erpair.org	

- Current draft of the VRH CCSA document included below. Current implementation is in PDSA and updates will be included in subsequent reporting:



**SOMETIMES WHAT IS GOING ON AROUND
CAN IMPACT WHAT'S GOING ON INSIDE You.**

Our team of professionals are available to assist you in reaching the quality of life you desire. This questionnaire will help us identify daily living areas that could impact your overall health. Please let us know if you need assistance in completing this questionnaire or have any questions.



Name _____
Date of Birth _____
Today's Date _____

1) DO YOU EVER NEED HELP READING OR UNDERSTANDING YOUR HEALTH INFORMATION?
 Yes No

2) WHAT IS YOUR HOUSING SITUATION TODAY?
(check one)
 I do not have housing (I am couch-surfing, in a motel, living on the street, in a car, an abandoned building or in a homeless shelter)
 I am in a transitional housing program
 I have housing today but I'm worried I may lose it in the next 90 days
 I have housing that is safe and adequate
 Other _____

3) IN YOUR HOUSING SITUATION, DO YOU HAVE ISSUES WITH ANY OF THE FOLLOWING?
(check all that apply)
 Bug infestation
 Mold
 Lead paint or pipes
 Not enough heat or hot water
 Oven or stove does not work
 No smoke detectors or the detectors do not work
 Water leaks in the building
 Other _____

4) IN THE PAST 3 MONTHS, HAS A LACK OF TRANSPORTATION KEPT YOU FROM MEDICAL APPOINTMENTS, MEETINGS, WORK OR FROM GETTING THINGS YOU NEED FOR DAILY LIVING?
 Yes, a lack of transportation has stopped me from going to medical appointments or getting medicine
 Yes, a lack of transportation has stopped me from going to work, appointments, meetings or getting things that I need
 No, I have transportation

5A) HOW HARD IS IT FOR YOU TO PAY FOR THE BASIC NEEDS LIKE FOOD, HOUSING, HEAT OR MEDICAL CARE? *(check one)*
 Not hard at all Somewhat hard Very hard

B) IF SOMEWHAT HARD OR VERY HARD, WHAT DO YOU HAVE TROUBLE PAYING FOR?
(check all that apply)
 Food
 Housing
 Utility bills (electric, oil, propane, etc.)
 Childcare
 Health needs (medicines, doctor, dentist, etc.)
 Debts
 Other _____

6) IN THE PAST 3 MONTHS, HAVE YOU FELT UNABLE TO AFFORD YOUR MEDICATIONS?
 Yes No

7) IN THE PAST 3 MONTHS, HAVE YOU FELT THE NEED TO SELL YOUR MEDICATIONS FOR FOOD, HOUSING, HEAT, ETC?
 Yes No

8) WHAT WAS YOUR MAIN ACTIVITY DURING THE LAST 6 MONTHS? *(check one)*
 Worked for pay
 Attended school
 Household duties
 Unemployed
 Permanently unable to work
 Retired
 Other _____



PATIENT QUESTIONNAIRE (continued)

9) DO YOU DRINK ALCOHOL OR USE NON-PRESCRIBED DRUGS?
 Yes No
(If no, skip to #14)

10) HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING OR DRUG USE?
 Yes No

11) HAVE PEOPLE ANNOYED YOU BY CRITICIZING YOUR DRINKING OR DRUG USE?
 Yes No

12) HAVE YOU FELT BAD OR GUILTY ABOUT YOUR DRINKING OR DRUG USE?
 Yes No

13) HAVE YOU EVER HAD A DRINK OR USED DRUGS FIRST THING IN THE MORNING TO STEADY YOUR NERVES OR TO GET RID OF A HANGOVER OR EYE-OPENER?
 Yes No

14) IN THE PAST 12 MONTHS, HAVE YOU BEEN THREATENED OR SCARED BY ANOTHER PERSON?
 Yes No

15) IN THE PAST 12 MONTHS, HAVE YOU BEEN FORCED TO PERFORM SEXUAL ACTS?
 Yes No

16) IN THE PAST 12 MONTHS, HAVE OTHERS SAID THAT THEY FEEL THREATENED OR SCARED BY YOU PHYSICALLY, EMOTIONALLY OR SEXUALLY?
 Yes No

17) DO YOU HAVE LEGAL ISSUES THAT ARE GETTING IN THE WAY OF YOUR HEALTH OR HEALTHCARE?
 Yes No

18) OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY THE FOLLOWING?	SEVERAL DAYS (1)	OVER HALF THE DAYS (2)	NEARLY EVERY DAY (3)	NOT AT ALL (0)
Feeling nervous, anxious or on edge				
Not being able to control or stop worrying				
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Thoughts that you would be better off dead or hurting yourself in some way				

19) ARE YOU CURRENTLY RECEIVING HELP FOR ANY NEEDS MENTIONED IN THIS QUESTIONNAIRE?
 Yes No

20) DO YOU HAVE SOMEONE YOU COULD CALL IF YOU NEED HELP OR A FAVOR?
 Yes No

WHAT ADDITIONAL NEED(S) DO YOU HAVE THAT IS NOT ADDRESSED ABOVE?

B1 Cheshire Medical Center Adult Primary Care Practice /Monadnock Family Services Integrated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care)

Historical Context: The IDN-1 Exec. Committee voted to approve a collaborative pilot bi-directional integration housed at Monadnock Family Services (MFS) with support from Cheshire Medical Center (CMC) Primary Care in W1. This project will tackle bidirectional integration with embedded primary care services available at MFS for highest acuity patients and likely commencing in early summer, 2018. Given staffing transitions at CMC and the implementation of a new EHR at the medical facility, the project start date has been delayed. However, the project team has met on a bi-weekly schedule continuously since May, 2018, focusing on program development and implementation plans. The primary proposal objectives of the project are as follows:

- Objective 1: Create, test and refine a co-located “reverse integration” Health Home Model that integrates professional disciplines and shared resources, with clients and their families, intended to afford the best possible health outcome.
- Objective 2: Assure that every individual in the Health Home has a comprehensive plan of care that effectively addresses their physical and behavioral health needs with a coordinated approach.
- Objective 3: Assist individuals in the Health Home with acquiring skills for managing their chronic illnesses in ways that reduce unnecessary emergency care and inpatient hospitalization, to be accomplished by a combination of lifestyle coaching, building self-management skills, greater peer supports, and coordination of primary care and behavioral health service delivery.
- Objective 4: Continuously improve client and staff experience (satisfaction and quality).
- Objective 5: Utilize the Region 1 shared IT platform to ensure coordinated care and communication across partners and care sites.
- Evaluate the project so that outcomes and lessons learned can be used to justify future replication and also to advocate for payment reforms that could sustain this approach to Coordinated Care Practice.

Current State:

- The CMC/MFS B1 team has begun meeting regularly, addressing work flows and program details until the identified staffing positions are in place. This has included the following:
 - Current state Primary Care review
 - Clinical space layout and planning at MFS
 - Address purchase of the medical equipment needed for the MFS exam room
 - Upcoming meetings are planned for July 18th, August 1st
 - IDN1 Program Director and Medical Director are supporting the ongoing meetings
- See below for draft of the current team charter:

PROJECT CHARTER

1. General Project Information				
Project Name:	Behavioral Health and Primary Care Integration (Region 1, B1 BHI)			
Executive Sponsor:	Region 1 Executive Committee			
2. Project Team				
	Name	Organization or Department Affiliation	Telephone	E-mail
Project Leads:	██████████	CMC	██████████	jpitts@cheshire-med.com
Data Lead:	██████████			
Practice Facilitator	██████████	CHI		
2 nd Prac. Fac	██████████	CHI		
MFS BH Lead	██████████	MFS	██████████	pwyzik@mfs.org
Team Member	██████████	MFS	██████████	mmarsh@mfs.org
Team Member	██████████	CMC	██████████	atremblay@cheshire-med.com
Team Member	██████████	CMC	██████████	slafrance@cheshire-med.com
Team Member	██████████	CMC	██████████	efernandes@cheshire-med.com
IDN Data Lead	██████████	IDN1		
IDN PM Lead	██████████	IDN1		
IDN MD Lead	██████████	IDN1		
Patient/Family Representative				
3. Stakeholders (e.g., those with a significant interest in or who will be significantly affected by this project)				
Individuals receiving services at MFS needing primary care, families of individuals served; public guardians				
Variety of social service organizations in the region				
Ancillary departments at MFS and CMC				
Monadnock Peer Support Agency, CMC – Prescribe for Health				
4. Project Scope Statement				
Project Purpose Describe the need this project addresses				
The purpose of this project is to: 1) reduce the burden of physical and mental illness for those clients ages 12 and older with behavior health conditions through the creation of an multidisciplinary team of professionals and peer supports using best-practice coordinated care interventions and 2) develop an effective and efficient model for co-locating a Health Home in a community mental health center to deliver integrated primary and behavioral health care services that will achieve the Quadruple Aim.				

Objectives Describe the measurable outcomes of the project (e.g., reduce cost by xx, increase screening rates by yy)

Objective 1: Create, test and refine a co-located “reverse integration” Health Home Model that integrates professional disciplines and shared resources, with clients and their families, intended to afford the best possible health outcome.

Objective 2: Assure that every individual in the Health Home has a comprehensive plan of care that effectively addresses their physical and behavioral health needs with a coordinated approach.

Objective 3: Assist individuals in the Health Home with acquiring skills for managing their chronic illnesses in ways that reduce unnecessary emergency care and inpatient hospitalization, to be accomplished by a combination of lifestyle coaching, building self-management skills, greater peer supports, and coordination of primary care and behavioral health service delivery.

Objective 4: Continuously improve client and staff experience (satisfaction and quality).

Objective 5: Utilize the Region 1 shared IT platform to ensure coordinated care and communication across partners and care sites.

Objective 6: Evaluate the project so that outcomes and lessons learned can be used to justify future replication and also to advocate for payment reforms that could sustain this approach to Coordinated Care Practice.

Improve health outcomes:

- Reducing ED visits
- Reduce hypertension rates
- Reduce diabetes rates
- Screening rates: colon cancer, mammography, (could we get baseline data at time of interview for this project), immunizations (flu, pneumonia, tetanus, etc.)

Deliverables List the high-level “products” to be created (e.g. process workflow created, shared care plan developed)

Creating the patient registry

Create access to EPIC for MFS staff

Shared care plan- PreManage

Create registry to identify BH, medical and social needs:

- Screenings
- Immunizations
- Chronic health conditions
- Other data sets: weight, BP, height, BMI
- Social determinants of health data: housing, income, social connection, transportation, food, exercise
- Routine care: oral health, BHG, medical

Creating the environment of care to ensure all needs are met for the patient in this setting

Evaluation plan developed

- Determine base line data needs
- Missed appointments
- Referrals made to external resources
- Determine ROI: what is the Price per visit cost

Scope <i>List what the project will and will not address (e.g., this project addresses all Medicaid patients, Medicare patients are not included)</i>	
<ol style="list-style-type: none"> 1) In Scope-Primare care services and care coordination provided to Medicaid beneficiaries age 12 and above who receive behavioral health services from MFS 2) Out of Scope – MFS clients over the age of 65 who do not have Medicaid insurance 3) Out of Scope – individuals whose only connection to MFS is through the Emergency Services department 	
Project Milestones <i>Propose start and end dates for Project Phases (e.g., Planning, Implementation) and other major milestones</i>	
See attached Project Milestones Guidance	
Measures & Outcomes <i>In this section list all objectives, measures, or outcomes including those listed in the AIM Statement.</i>	
▪	
Major Known Risks <i>Identify obstacles that may cause the project to fail (e.g. funding, time)</i>	
Risk	Risk Rating (Hi, Med, Lo)
Primary Care Provider not available	High
Supply costs	Low
Clients do not want primary care services	Low
Region 1 IDN funding is not available for future years	Medium
Sustainability impacted due to current funding processes	Medium

Standard data reporting required as part of the B1 Integrated Healthcare Project:

Measure Category	Measure
Follow-up After ED Visit or Hospitalization	<i>Readmission to Hospital for Any Cause (excluding maternity, cancer, rehab) at 30 days for Adults 18+ BH pop.</i>
Follow-up After ED Visit or Hospitalization	<i>Follow-up after ED visit for alcohol and other drug dependence within 30 days</i>
Follow-up After ED Visit or Hospitalization	<i>Follow-up after ED visit for mental illness within 30 days</i>
Follow-up After ED Visit or Hospitalization	<i>Follow up after hospitalization for mental illness within 30 days</i>
Follow-up After ED Visit or Hospitalization	<i>Follow up after hospitalization for mental illness within 7 days</i>
Integration and Core Practice Competencies	<i>% of patients screened for alcohol or drug abuse in the past 12 months using an age appropriate standardized alcohol and drug use screening tools AND if positive, a follow-up plan is documented on the date of the positive screen age 12+</i>
Integration and Core Practice Competencies	<i>Timely electronic transmission of transition record (discharges from an inpatient facility in IDN (including rehab and SNF) to other home/self-care or any other site of care)</i>
Patient Reported Experience of Care	<i>Global Score for mini- CAHPS Satisfaction Survey at IND level for kids and adults</i>
Physical Health/Primary Care clinical Quality/Screening and Assessment	<i>Comprehensive and consistent use of standardized core assessment framework including screening for substance use and depression for age 12+ by IDN providers</i>
Physical Health/Primary Care clinical Quality/Screening and Assessment	<i>Global score for selected general HEDIS physical health measures, adapted for BH population</i>
BH Care Clinical	<i>Global score for selected BH-focused HEDIS measures</i>
Physical Health/Primary Care clinical Quality/Screening and Assessment	<i>% of BH population with all recommended USPSTF A&B Services</i>
Physical Health/Primary Care clinical Quality/Screening and Assessment	<i>Recommended Adolescent (age 12-21) Well Care visits</i>
Physical Health/Primary Care clinical Quality/Screening & Assessment	<i>Smoking and tobacco cessation counseling visit for tobacco users</i>
Population Level Utilization	<i>Frequent (4+ per year) ER visits users for BH population</i>
Population Level Utilization	<i>Potentially preventable ER visits for BH population and total population</i>
Population Level Utilization	<i>Rate per 1000 of people without cancer receiving a daily dosage of opioids greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer</i>
Workforce Capacity	<i>Engagement of alcohol and drug dependence treatment (initiation and 2 visits within 44 days)</i>

Workforce Capacity	Initiation of Alcohol and other drug dependence treatment (1 visit within 14 days)
Workforce Capacity	% of new patient call of referral from other provider for CMHC intake appointment within 7 calendar days
Workforce Capacity	% of new patients where intake to first follow-up visit was within 7 days after intake

- The CMC/MFS has engaged a B1 QI Coach contracted through Citizens Health Initiative (CHI). The coach has a standing relationship with MFS on their ongoing QI work with CHI. Additionally, given her extensive experience with the Community Mental Health Center (CMHC) network infrastructure in NH, she has a unique view into the development of the CMC/MFS reverse integration project development.
- A small group comprised of the primary non-clinical lead at CMC, IDN1 Program Director, and CHI QI coach are meeting weekly to target a formal work plan development to share with the larger clinical team at the mid-August meeting.
 - This small group will serve as the steering body to guide agenda development and support efforts for team progress between large group meetings.
- The CMC non-clinical lead is working directly with their IT/Data department to pull an initial patient registry list for those high acuity patients with a BH indication that are shared between CMC primary care and MFS adult services.
 - The initial data pull will identify shared patients across all of the CMC primary care providers and the team will target a phased launch with PCP's as the project gets underway.
- The MFS team will also pull data in advance of an August target and identify clinical supports to attend and inform the large group project team planning sessions. The MFS team is identifying an additional subset of patients which will be the focus of an intervention planned to begin in August. These patients with physical health needs will be supported by clinical staff working with MFS staff.
- Additional actions underway include:
 - Completion of the Team Charter
 - Shift to ongoing Biweekly meetings for the Project team steering group
 - Inclusion of PCPs at 1x monthly session
 - Inclusion of designated BH clinical lead at 1x monthly session
 - Completion of Project Work Plan and disseminate to all participants
 - Draft document of all project identified outcomes measures
- Given the early stage of project development and slow rollout of the clinical team the IDN1 team accounts for the slow build of the CMC/ MFS pilot but anticipates substantial growth in the upcoming semi-annual period.

B1 Onboarding Projects:

Newport Health Center

- The IDN1 full admin team have met with the New London Hospital administrative staff several times in the January-June timeframe to discuss onboarding new projects and organizational engagement. The group has decided to move forward with a B1 project at its Newport Health Center (NHC) site which will initially focus on the adolescent pediatric population and expand to

include the >12 and adult population served. Newport Health Center has a high Medicaid volume and is well-poised for the B1 project with the internal resource of a Psychiatrist and 1 FTE MSW. Additionally, the site shares space with Counseling Associates who currently offer BH services to patients 2 days a week. For the pediatric population NHC partners with the Newport School District in Newport High School through its work at the Tiger Treatment Center, which is currently staffed several mornings a week with a NHC clinician. The B1 project physician champion, is a pediatrician and the MSW coordinator are both committed to the vision of expanded services at the Tiger Treatment Center and partnering more directly with other BH services offered within the community for their high needs pediatric population. This unique model will look to embed CCSA screening within NHC as well as expanded services at the Tiger Treatment Center to identify patients who are eligible for the MDCT and augment existing crisis response with the population at NHC. As of June 30, 2018 the project team at NHC is finalizing their full proposal document and the contract scope of work. To support the development of these materials, the IDN1 Program Director has been meeting with the team bi-weekly throughout late May and June. The team anticipates a soft launch to come early August, 2018.

Dartmouth Hitchcock- General Internal Medicine Practice

- With the success and expansion of the DH-HRS B1 team, additional practices at Dartmouth-Hitchcock in Lebanon are preparing to implement B1 projects. The General Internal Medicine (GIM) practice located in the Dartmouth-Hitchcock Medical Center (DHMC) has identified a physician champion who has been attending IDN1 meetings for several months, coordinating internal DH improvement projects with the DSRIP work. The GIM practice based in DHMC has been deeply involved in the Substance Use Mental Health Initiative (SUMHI) work taking place at DH and has been piloting an MAT program. The IDN1 team has engaged with the GIM practice manager and physician champion to identify the GIM project team and to define the scope of work (SOW). The team will follow the same implementation playbook as created by the DH Heater Road practice which will accelerate their onboarding process. The current practice includes 2 FTE BHC's but is not yet supported by a CHW. The IDN is working directly with departments within DH to secure a CHW for the group. As of June 30, 2018 the team is reviewing scope of work and details of the project proposal.

Monadnock Community Hospital (MCH) - Hospital Based Primary Care Practice

- [REDACTED]

After several recent meetings with the IDN1 team, the hospital-based primary care practice is now onboard to move forward with a B1 project. At time of this writing the SOW, Contract and draft proposal are out for review. A follow-up meeting is set for July 20th. If all moves forward from this meeting the IDN1 team anticipates moving quickly to bring its HIT team onboard, enable those services and set up regular project team meetings.

Alice Peck Day Memorial Hospital Primary Care-

- The APD system is undergoing substantial changes and will continue to do so through their transition to D-H enabled services in fall of 2018 and Epic implementation in early 2019. Consequently the current state the practice is grappling with how best to move B1 forward, and decide what components are feasible mid-transition. The IDN1 team continues to meet regularly with the APD team to identify next steps and determine a timeline. Additional information will be shared as soon as it's available.

B1 Onboarding Support Partners:

Phoenix House

- The IDN1 admin team met with Phoenix House (Keene), which provides outpatient and inpatient SUD treatment services, leadership in June, 2018 to review the most recent data on their population and address coordination with the B1 project. Given limited numbers of Medicaid members seen, and the spread of patients across the Keene and Dublin sites, the IDN1 admin team is still addressing coordinated involvement. Phoenix House is already aligned with MFS/CMC on a HRSA SUD grant, so it will be directly involved as a support for the B1 work as well. Additionally, as TAP21 screening is only being captured for those patients with payer of last resort (BDAS), the IDN1 team is working to develop a crosswalk to the CCSA, then follow up with PH's clinical director to assess the feasibility of implementation and next steps. Additional information will be shared as soon as it's available.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

From the IDN HIT Infrastructure Project Plan, use the format below to identify the progress toward process targets, or goals, that the project has achieved.

Given the phased rollout of B1 practices in IDN1, and the delays met by some of the project teams, the evaluation project targets vary in their current scope of implementation. Some measures are currently affected by the ongoing B1 pilot teams; others have launched and begun to meet implementation measures due to the HIT implementation and rollout.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Organizations Assessing Medicaid Members with the CCSA	9	1	2	
# Organizations Contributing to and/or accessing Shared Care Plan	9	1	2	
# Organizations Initiating Referrals to Supports	9	1	2	
# Organizations Receiving Referrals to Supports	9	2	2	
# of Organizations meeting requirements of "Coordinated Care Practice"	9	0	2	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of Organizations meeting requirements of "Integrated Care Practice"	4	0	0	

Please note that the number reflected in the Target is inclusive of only the Primary B1 partners in IDN1 which are:

- APD
- CMC/DHK
- DH Lebanon Primary Care Sites
- DH Psychiatry
- MCH
- MFS
- NLH, NLP, and NHC
- VRH
- WCBH

This distinction in the targets was made given that these primary leads of the B1 projects are the only organizations that will be able to be assessed for all of the measures and the only organizations that could stand alone when reviewed for assessment of coordinated care designation.

B1-4. IDN Integrated Healthcare: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, provide the current number of full-time equivalent (FTE) staff specifically related to this project using the format below.

IDN1 Administrative staff and leadership are still in ongoing conversations with many partners regarding their readiness for B1 implementation. One major factor affecting this readiness is the high need for primary care providers and support positions at many partner sites. With lean teams and recurring vacancies the internal capacity of many partner agencies is severely limited. While there is organizational support of the IDN, there have been ongoing challenges in securing physician and clinical champions for B1 implementation. Additionally, many of the IDN1 B1 partners are working on expanding MAT services within their organizations and the topic of MAT capacity is recurring at many IDN workforce and project meetings. In regard to staffing as the B1 projects expand from their initial implementation we anticipate targeting hiring and staffing allocations specifically to MAT. More information will be provided in upcoming reporting periods.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Dartmouth-Hitchcock Heater Road South Primary Care	1	1	1	1	
Dartmouth Hitchcock Psychiatry					
West Central Behavioral Health-Lebanon Site					
Dartmouth Hitchcock Keene/Cheshire Medical Center: Hospital Based Primary Care	1	0	0	Recruit to Hire for 1 Position	
Monadnock Family Services	1	0	0		
Alice Peck Day Hospital Based Primary Care Practice	1	0	0	0	
Monadnock Hospital Primary Care-Peterborough Practice	1	0	0	0	
New London Hospital and Medical Group Practice, Pediatric Care Practice, Newport Health Center	2	0	0	Recruit to Hire for 1 Position	
Valley Regional Hospital Primary Care Practice	1	0	Recruit to Hire	1	
Child and Family Services	B1 Support Partner- No direct hire expected				
Southwestern Community Services	B1 Support Partner- No direct hire expected				
Crotched Mountain Community Care	B1 Support Partner- No direct hire expected				
MAPS	B1 Support Partner- No direct hire expected				
Mindful Balance Therapy Center	B1 Support Partner- No direct hire expected				
Phoenix House	B1 Support Partner- No direct hire expected				
TLC Family Resource Center	B1 Support Partner- No direct hire expected				
Counseling Associates	B1 Support Partner- No direct hire expected				
Headrest	B1 Support Partner- No direct hire expected				
Mascoma Community Health	B1 Support Partner- No direct hire expected				

B1-5. IDN Integrated Healthcare: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting

The budgets below are broken out by current project team and include projections through 2021 based on current subcontracts. These budgets have been constructed to include all known components of IDN operations and projects to date by CY but is subject to change as more details are determined in the upcoming implementation periods. Additionally, as IDN1 project subcontracts are created on implementation year and these focus on CY the balance of funds is slightly variable.

DH-HRS/ WCBH:

			\$ 24,000.00	\$ 40,000.00	\$ 30,000.50
			\$ 8,427.00	\$ 20,824.00	\$ 10,427.00
			\$ -	\$ 14,000.00	\$ 7,000.00
			\$ 2,379.00	\$ 500.00	\$ 250.00
			\$ -	\$ -	\$ -
			\$ -	\$ 3,500.00	\$ 1,750.00
			\$ -	\$ -	\$ -
			\$ -	\$ -	\$ -
			\$ 35,615.00	\$ 98,857.00	\$ 49,428.50

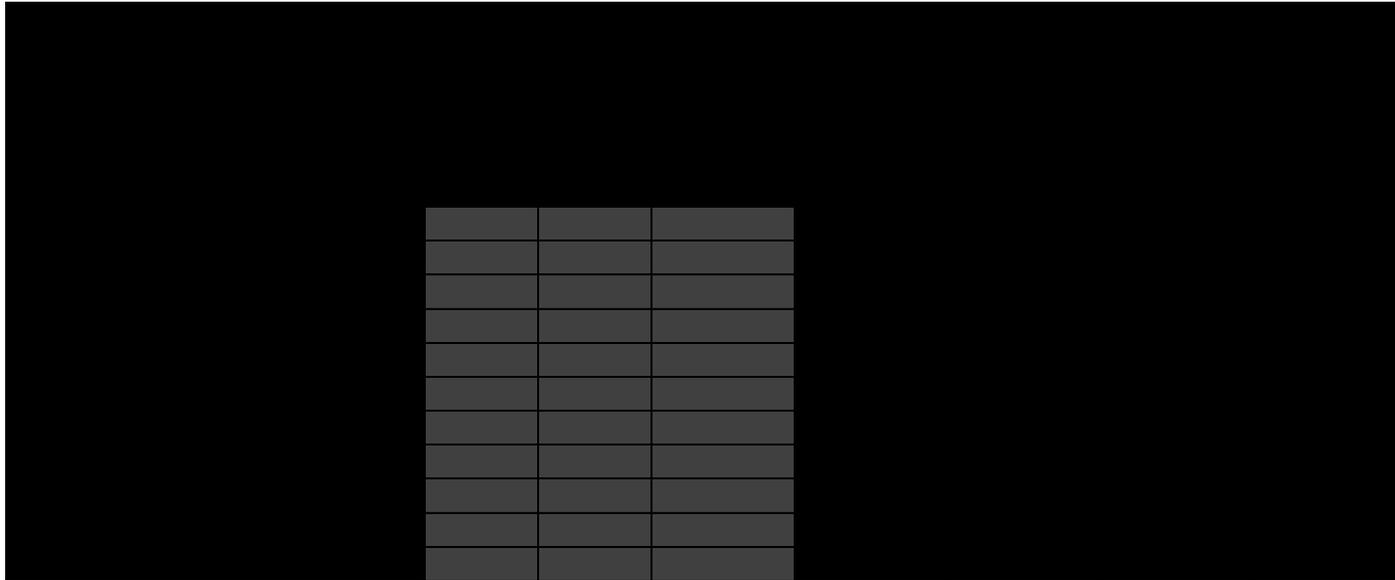
VRH/CA:

			\$ 2,153.85	\$ 71,588.00	\$ 36,509.00
			\$ -	\$ 20,004.00	\$ 10,222.50
			\$ 7,982.50	\$ -	\$ -
			\$ 250.00	\$ 1,500.00	\$ 780.00
			\$ -	\$ 25,000.00	\$ -
			\$ 146.45	\$ 750.00	\$ 375.00
			\$ -	\$ 44,000.00	\$ 22,000.00
			\$ -	\$ -	\$ -
			\$ -	\$ 7,500.00	\$ -
			\$ 5,720.00	\$ 11,000.00	\$ 5,500.00
			\$ 16,232.80	\$ 181,442.00	\$ 75,386.50

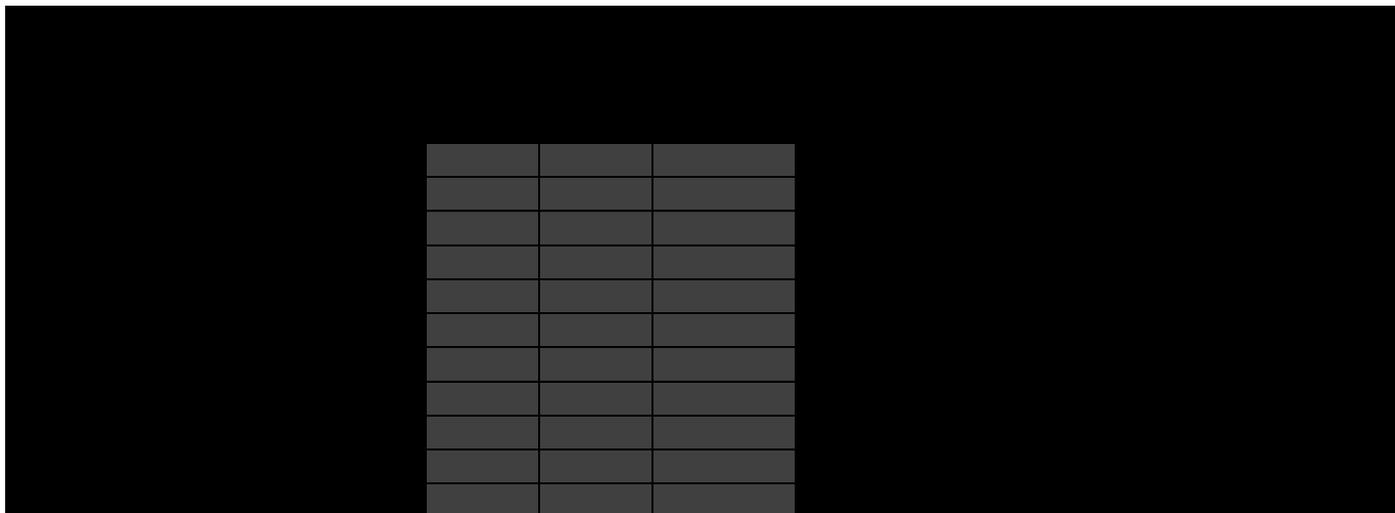
CMC/MFS:

			\$ 156,259.00	\$ 79,692.14
			\$ 43,659.21	\$ 22,309.50
			\$..	\$..
			\$..	\$..
			\$..	\$..
			\$ 5,000.00	\$..
			\$..	\$..
			\$..	\$..
			\$..	\$..
			\$..	\$..
			\$ 204,918.21	\$ 102,001.64

Projected Core B1 Projects and Budgets: All budgets listed below are projections by organization based on the IDN1 administrative B1 budget



This table is almost entirely redacted with a black background. Only a central 3x10 grid of cells is visible, representing the data structure.



This table is almost entirely redacted with a black background. Only a central 3x10 grid of cells is visible, representing the data structure.

This table is redacted with a black background. It contains 3 columns and 12 rows of data.

This table is redacted with a black background. It contains 3 columns and 12 rows of data.

				\$	10,000
				\$	5,000
				\$	10,000
				\$	18,000
				\$	43,000.00
				\$	--

				\$	10,000
				\$	5,000
				\$	10,000
				\$	18,000
				\$	43,000.00
				\$	--

				\$ 5,000	
				\$ 3,000	
				\$ 5,000	
				\$ 10,000	
				\$ 23,000.00	\$

				\$ 5,000	
				\$ 3,000	
				\$ 5,000	
				\$ 10,000	
				\$ 23,000.00	\$

				\$ 5,000	
				\$ 3,000	
				\$ 5,000	
				\$ 10,000	
				\$ 23,000.00	\$

B1 All Project Budgets

As IDN 1 looks to launch the B1 projects at all of the primary care provider sites in conjunction with the community mental health centers and supporting partners, the total B1 budget has been revised to support IDN 1 partners' engagement and reflect the number of Medicaid Members attributed to the partner organizations. ([REDACTED]

[REDACTED].) The final budget for each partner is refined through an iterative process as the Program Director helps each organization finalize its B1 scope of work and customize to the local environment. IDN 1 will also be offering incentives to the Community Mental Health Centers and smaller Behavioral Health providers to participate in the local B1 projects including confirming position to receive referral, facilitating engagement on the MCDT and submitting required data for reporting. This projected budget will result in the utilization of \$4.99M which aligns with the projected \$5.6 less contingency. However, as Region 1 IDN deploys these projects in the next 6 months and tracks the progress over the next 12 months, the team will review successes, challenges and overall effectiveness in order to determine how funding shall continue for the last 12 months – all natural action items in a PDSA cycle inherent within a demonstration project.

The budget table below includes total projections by organization site for the remaining 2.5years of project implementation expenditures through 2021 by CY. This budget has been constructed to include all known components of IDN operations and projects to date by CY but is subject to change as more details are determined in the upcoming implementation periods.

B1-6. IDN Integrated Healthcare: Key Organizational and Provider Participants

Organization/Provider	Agreement Executed (Y/N)
Dartmouth Hitchcock Primary Care: Heater Rd. South Practice: S1, S2, S3 Teams	Y
Dartmouth Hitchcock Psychiatry	Y
West Central Behavioral Health: Adult Lebanon Based Teams	Y
Dartmouth Hitchcock Keene/Cheshire Medical Center Hospital Based Primary Care - Adult Teams	Y
Monadnock Family Services: Keene Adult Teams	Y
Alice Peck Day Hospital Based Primary Care Practice	Y
Monadnock Hospital Based Primary Care Practice	Y
New London Hospital and Medical Group Practice and Pediatric Care Practice, Newport Health Center Pediatric Practice	Y
Valley Regional Hospital Based Primary Care Practice	Y
Counseling Associates	Y

B1-7. IDN Integrated Healthcare: IDN Governance Leadership Sign-off

Changes to the table are representative of add-on leadership sign off from Counseling Associates.

Name	Title	Organization	Sign Off Received (Y/N)
Chelsea Worthen	Practice Manager at Heater Road	Dartmouth Hitchcock Heater Rd. Practice	Y
Dr. Will Torrey	Head of Psychiatry	Dartmouth Hitchcock Psychiatry	Y
Suellen Griffin	CEO	West Central Behavioral Health	Y
Dr. Les Pits	Director of Primary Care	Dartmouth Hitchcock Keene/Cheshire Medical Center Hospital Based Primary Care	Y
Phil Wyzik	CEO	Monadnock Family Services	Y
Lauren Senn	Practice Manager	Alice Peck Day Hospital Based Primary Care Primary Care	Y
Sally Patton, RN	Chief Nursing Officer	New London Hospital and Medical Group Practice	Y
		New London Pediatric Care	Y
		Newport Health Center Practice	Y
Angela Biron	Director of Physician Practices	Valley Regional Hospital Primary Care Practice	Y
Susan Borchert	Partner	Counseling Associates	Y

B1-8. Additional Documentation as Requested in B1-8a-8h

a. All of the following domains must be included in the CCSA:

- Demographic information
- Physical Health Review
- Substance Use Review
- Housing Assessment
- Family and Support Services
- Educational Attainment
- Employment or entitlement
- Access to Legal Services
- Suicide Risk Assessment
- Functional Status Assessment
- Universal screening using depression screening (PHQ 2 & 9)
- Universal screening using SBIRT

For pediatric providers, the CCSA must also include:

- Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits
- Developmental screening using Bright Futures or other American Academy of Pediatrics recognized screening.

b. List of multi-disciplinary core team members that includes, at minimum:

- PCPs
- Behavioral Health Providers (including a psychiatrist)
- Assigned care managers or community health worker.

c. Multi-disciplinary core team training for service providers on topics that includes, at minimum:

- Diabetes hyperglycemia
- Dyslipidemia
- Hypertension
- Mental health topics (multiple)
- SUD topics (multiple).

d. Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management.

e. Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions.

f. Secure Messaging

g. Closed Loop Referrals

h. Documented workflows and/or protocols that include, at minimum:

- Interactions between providers and community based organizations
- Timely communication
- Privacy, including limitations on information for communications with treating provider and community based organizations
- Coordination among case managers (internal and external to IDN)
- Safe transitions from institutional settings back to primary care, behavioral health and social support service providers
- Adherence to NH Board of Medicine guidelines on opioid prescribing.

B1.8a CCSA Utilization

IDN1 has established a gold standard for the CCSA screenings throughout the Region- see CCSA protocol below. Utilizing the protocol documents the gold standard CCSA will be made available in the rollout of B1 projects. Given the disparate nature of the B1 partners in IDN1, the decision was made to allow for variability in the tools used for the CCSA. When alternate tools are used, the IDN team will require documentation of the alternate tools in the report on the data capture. The IDN1 Medical Director will then approve the use of the substitute screening tool (s) for use as the CCSA.

CCSA Substitutes Approved as of 6/30/18:

- WCBH- DLA20
- MFS- CANS/ANSA
- Pending: CA Intake Documentation and BH Assessment Panel

The table below reflects utilization by organization as of 6/30/18. At the other B1 project team sites (CMC, MFS, VRH) the IDN team is supporting the rollout of the CSA process and building new clinical workflows around the process.

		Utilization January 1, 2018- June 30, 2018											
		Demographic Information	Physical Health Review	Substance Use Review	Housing Assessment	Family and Support Services	Educational Attainment	Employment or Entitlement	Access to Legal Services	Suicide Risk Assessment	Functional Status Assessment	Universal Screening: PHQ2,9	Universal screening: SBIRT
Providers													
Alice Peck Day Hospital Based Primary Care		Anticipated utilization after launch- projected not later than October, 2018											
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care		Anticipated utilization after launch- projected not later than September, 2018											
Dartmouth-Hitchcock Heater Road Primary Care Practices		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Dartmouth-Hitchcock Psychiatry	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Monadnock Family Services	Deployment Underway												
New London Hospital and Medical Group Practice and Pediatric Primary Care Practice , Newport Health Center Practice	Deployment Underway												
Valley Regional Hospital Based Primary Care Practice	Deployment Underway												
West Central Behavioral Health	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Counseling Associates	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y

See below for IDN1 CCSA Protocol: This serves as a guideline for all IDN1 partner projects



Integrated Delivery Network Region 1 (IDN1) Comprehensive Core Standardized Assessment (CCSA) Protocol

V1.0 June 2018

The purpose of this document is to guide IDN-1 Partners in broad screening of Medicaid Members, follow up to positive screening results, and associated quality reporting. This is a living document that will evolve to meet the needs of IDN-1 Partner organizations as they serve the region's Medicaid Members. This document has been approved by IDN1 Administration Team. For questions, please contact Mark Belanger at mbelanger@maehc.org.

Last Updated 6/30/18

Contents

Introduction 121

Who Is to Be Screened, By Whom, Where, and When? 123

Screening Domains and Questions 124

- Domain 1: Demographics:..... 126
- Domain 2: Depression 126
- Domain 3: Substance Use..... 128
- Domain 4: Medical 131
- Domain 5: Housing 132
- Domain 6: Family and Support Services (Social Isolation) 133
- Domain 7: Education 133
- Domain 8: Employment and Entitlements 134
- Domain 9: Legal..... 134
- Domain 10: Risk Assessment Including Suicide Risk 135
- Domain 11: Functional Status 136
- Domain 12: Developmental and Behavioral Health screening (Pediatrics) 136

Response to Positive Screens 137

- Response Pathway 1: Immediate Response 138
- Response Pathway 2: Brief Intervention and Referral to Treatment..... 138
- Response Pathway 3: Brief Intervention and Referral to Supports 139
- Response Pathway 4: Enhanced Care Coordination..... 139

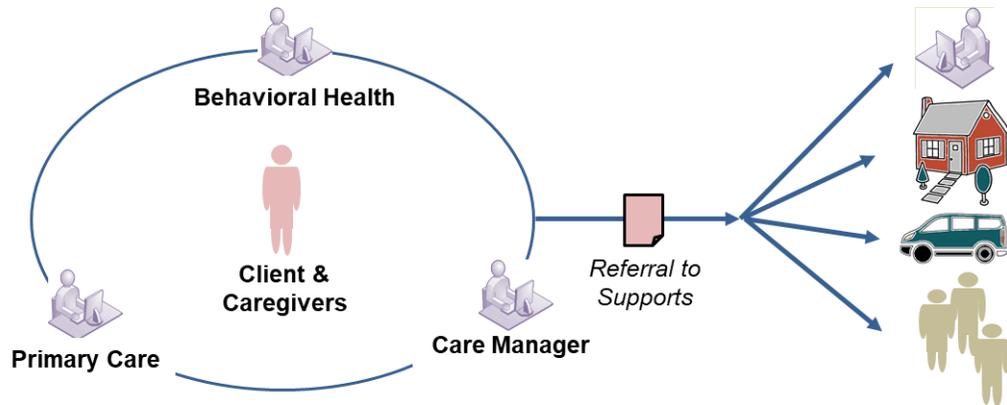
Appendix A: Adult (age 18+) CCSA Questions, Survey Logic, and Interpretation 140

Version Change Log

Version #	Date of Change	Description of Change
1.0	6/30/18	Initial publication

Introduction

At the core of the NH 1115 Waiver is the discovery of the unmet needs of Medicaid Members, connection of members to a range of supports for physical, behavioral, and social determinants of health, and improved care coordination for complex Members.



The following principles guide deployment of screening for IDN-1 Partners:

1. The CCSA process is intended to discover the unmet needs of Medicaid Members and to prompt Partners to help connect Members with supports and enhanced care coordination where needed.
2. Screening and connection to supports is a choice for each Medicaid Member and she/he should be asked if she/he welcomes additional support
3. CCSA questions are intentionally broad but not deep – Positive answers to the questions indicate that further assessment, intervention, and connection to supports may be beneficial to the Medicaid Member
4. The CCSA will follow evidence-based practice where it exists and will pilot screening questions and interventions where current evidence is weak
5. Partners should not discontinue screening that is working well – but should fill gaps and move to standardized screening instruments over time.
6. Screening requires capacity to respond and will be deployed in tandem with enhanced care coordination and formalization of support referral networks.

The following Protocol will define the following:

- Who Is To Be Screened, By Whom, Where, and When?
- Screening Domains And Questions
- Response To Positive Screens
- CCSA Questions, Answers, Survey Logic, and Interpretations

Who Is to Be Screened, By Whom, Where, and When?

Population to Be Screened: Any NH Medicaid Member that is 12 years and older.

Medicaid Member is defined as patients that hold Medicaid as primary or secondary insurance. This includes programs managed directly by NH Medicaid, Medicaid Expansion plans managed by commercial payers and managed care organizations (MCOs), and Prescription Assistant Programs (PAP).

Providers to Perform Screening: Any primary care or behavioral health Medicaid billing provider.

The IDN's Medicaid Billing Provider is defined as a provider who is part of Region 1 and who is enrolled as a NH Medicaid Billing provider.

Where Screenings are performed: As part of a Medicaid Member's visit in an office or community-based setting. The screening is intended to occur prior to or during an encounter. IDN-1 recommends that the screening be offered in one or more of the following mediums:

- Screening prior to the visit via a patient portal or online application
- Screening at appointment check in via tablet or paper application

"Office and Community Based Settings" exclude the hospital.

"Office and Community Based Settings" include the following (with UB codes): 03 – School, 04- Homeless Shelter, 11 – Office, 12- Home, 13 – Assisted Living Facility, 14 – Group Home, 15 – Mobile Unit, 16 – Temporary Lodging, 17 – Walk-in Retail Clinic, 18 – Place of Employment, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility, 71 – Public Health Clinic, 72 – Rural Health Clinic

When Should Screenings be performed: At least once per year for Medicaid Members that present for a non-urgent Primary Care or Behavioral Health visit.

The CCSA is to be delivered all at once and by a single provider organization.

- Note: Measurement of CCSA delivery occurs every 6 months with a 1-year look-back.
- Note: Distributing parts of the CCSA among provider organizations (e.g., AUDIT screen by one organization and PHQ by another) and/or over multiple visits is not an accepted practice by the NH Department of Health and Human Services (DHHS) and will not count for measurement.

Screening Domains and Questions

The Comprehensive Core Standardized Assessment (CCSA) will include the following domains as required by NH Department of Health and Human Services:

1. Demographic
2. Depression
3. Substance use (including SBIRT)
4. Medical
5. Housing
6. Family & support services
7. Education
8. Employment and entitlement
9. Legal
10. Risk assessment including suicide risk
11. Functional status (activities of daily living, instrumental activities of daily living, cognitive functioning)
12. (Pediatrics) Developmental and Behavioral Health screening

Region 1 recommends validated and evidence-based screening tools for each domain. The following screening tools make up the recommended CCSA for adults 18+. Note that the screening tool recommendation for adolescents age 12-17 is under development.

Table 1: IDN-1 Recommended CCSA Screening Tools - Adult

Domain	Recommended Screening Tools
1. Demographics	Standard Registration Fields
2. Depression	PHQ-2, PHQ-3, and/or PHQ-9
3. Substance Use	AUDIT and DAST
4. Medical	Kaiser Permanente, University of California, "Your Current Life Situation Survey"
5. Housing	DH SDOH Screening
6. Family & Support Services	DH SDOH Screening
7. Education	DH SDOH Screening
8. Employment and Entitlement	DH SDOH Screening
9. Legal	DH SDOH Screening
10. Risk assessment including suicide risk	DH SDOH Screening
11. Functional status	Medicare Outcomes Survey - ADL & IADL
12. (Pediatrics) Developmental and Behavioral Health screening	"Bright Futures" or other American Academy of Pediatrics validated screens for general and socio-emotional development

IDN-1 offers a CCSA to our Partners including questions, answer choices, survey logic, and interpretation. The adult CCSA is available in Appendix A.

IDN-1 also recognizes that Partners already use a wide range of screening instruments with their patients and the administrative team does not wish to disrupt this good practice. Partners that wish to use existing screening instruments or substitute questions to the “Off the Shelf” CCSA may do so. In order for these screening instruments to count for quality reporting, they must be reviewed and approved by the IDN-1 Medical Director, Peter Mason. Screening instruments that have been approved are as follows:

Table 2: IDN-1 Approved Alternate Screening Tools

Approved Alternate Screening Tool	Description
Daily Living Activities (DLA-20) Functional Assessment	<p>Many Community Mental Health Centers administer the DLA-20 as part of behavioral health care provision. The DLA-20 questions cross-walk to the required CCSA domains, are approved by IDN-1, and count toward the CCSA quality measure.</p> <p>The DLA-20 is offered by MTM Services in Partnership with the National Council for Behavioral Health. They describe the instrument as follows: <i>“The Daily Living Activities–20 (DLA-20) measures the daily living areas impacted by mental illness or disability and supports the functional assessment data needs of service providers.”</i></p>
Adults Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) [New Hampshire	<p>Many behavioral health providers administer the ANSA (for adults) and CANS (for children) as part of behavioral health care provision. The ANSA and CANS questions both cross-walk to the required CCSA domains, are approved by IDN-1, and count toward the CCSA quality measure.</p> <p>(Note that many organizations that administer the ANSA also administer the Phoenix for employment status. While the ANSA has employment related questions and satisfies the employment domain, IDN-1 believes the Phoenix has better employment questions and recommends these tools be used together.)</p>
Technical Assistance Protocol (TAP) 21	<p>Substance Use Disorder Treatment providers are required to administer the TAP-21 as a condition under the Bureau of Drug and Alcohol Services. NH DHHS has determined that the TAP-21 satisfies the requirements for a CCSA and counts toward the CCSA quality measure.</p>

Domain 1: Demographics:

Region 1 recommends that Partners gather standard demographic information as part of Member intake/registration.¹ This information should be stored and periodically updated in the Partner's electronic health record and/or practice management system.

- Demographic information should include: Name, Address, Phone Number(s), Date of Birth, and Medical Record Number (if used)
- For stronger identity matching among healthcare organizations that see the same Medicaid Member, consider including: Medicaid ID, Mother's Maiden name, Patient Alias, SSN, Driver's license identifier, Birth Place, Multiple Birth (twin, triplet) indicator and birth order.
- For public health measurement purposes, it is recommended that Partners gather demographic information questions relevant to health access disparities at the option of the Medicaid Member including: Sex/Gender, Race, Ethnicity, Primary Language, Marital Status, Citizenship, Veterans Military Status, Nationality

Domain 2: Depression

Region 1 recommends that Partners use the Patient Health Questionnaire PHQ 2, PHQ 3, and/or PHQ 9 for Depression Screening.²

- PHQ-2 is the first 2 questions of the full screen and may be used as a shorter screen with branching logic that queues questions 3-9 when PHQ-2 score is positive.
- PHQ-3 is the first 2 questions and last (suicide ideation question) of the full screen and may be used as a shorter screen with branching logic that queues questions 3-8 when PHQ-3 score is positive.
- PHQ-9 may also be administered on its own where there is no branching logic.
- Partners should have an immediate response protocol in place for question 9, which assesses suicide ideation.

Interpreting Results:

- PHQ-2 Positive Result: 3 triggers PHQ-9
- PHQ-3 Positive Result: 3 triggers PHQ-9
- PHQ-9 Positive Result: 10+
- **ANY ANSWER ABOVE 0 FOR QUESTION 9 TRIGGERS SUICIDE RISK RESPONSE**

¹ HL7 Patient Identification (PID) data fields, Health Level Seven Message Profiling Specification version 2.x. www.HL7.org

² Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute. http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

Table 3: PHQ-9 Example

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? <i>(Use "✓" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Domain 3: Substance Use

Region 1 recommends that Partners use the Alcohol Use Disorders Identification Test (AUDIT) for Alcohol Use Screening and the Drug Abuse Screening Test (DAST-10) for Drug Use Screening.³

- AUDIT-C is the first 3 questions of the full screen and may be used as a shorter screen with branching logic that queues questions 4-10 when positive. AUDIT 10 may also be administered on its own where there is no branching logic.
- DAST-1 is the first question of the full screen and may be used as a shorter screen with branching logic that queues questions 2-10 when positive. DAST 10 may also be administered on its own where there is no branching logic.

Interpreting Results:

- AUDIT-C Positive Result: 4 or higher (men), 3 or higher (women)
- AUDIT-10 Positive Result: 6+
- DAST-1 Positive Result: 1
- DAST-10 Positive Result: 6+

³ Source: National Institute on Drug Abuse, <https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf>, <https://www.drugabuse.gov/sites/default/files/dast-10.pdf> ; SAMSHA, *Audit-C* https://www.integration.samhsa.gov/images/res/tool_auditc.pdf ; *Audit Screen.org* <http://auditscreen.org/~auditscreen/page.php?Download-2>

Table 4: AUDIT Example

The Alcohol Use Disorders Identification Test: Self-Report Version						
<p>PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.</p>						
Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Table 5: DAST Example

These questions refer to the past 12 months.	No	Yes
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Domain 4: Medical

Region 1 recommends a question modified from Kaiser Permanente, University of California, “Your Current Life Situation Survey:”⁴

1. How is your health? (Excellent, Very Good, Good, Fair, Poor)

Interpreting Results:

- “Fair” and “Poor” are positive scores.

Region 1 has found that many Partners currently use broad spectrum screens that contain questions that effectively assess the Medical domain. Some of these screens are proprietary and require fees. To date, Region 1 supports use of the following screening questions for the Medical domain:

- Kaiser Permanente, Your Current Life Situation Survey, questions 11 and 12
- PROMIS 10 question 1⁵
- DLA-20 question 1 “Health Practices” (clinician administered)⁶

⁴ Kaiser Permanente, Your Current Life Situation Survey, University of California San Francisco, Social Interventions Research and Evaluation Network (SIREN), <https://sirenetwork.ucsf.edu/tools-resources/mmi/kaiser-permanentes-your-current-life-situation-survey>

⁵ PROMIS 10: Health Measures, <http://www.healthmeasures.net/explore-measurement-systems/promis>

⁶ DLA-20: National Council for Behavioral Health, <https://www.thenationalcouncil.org/webinars/dla-20-functional-assessment-for-persons-with-serious-mental-illness/>

Domain 5: Housing

Region 1 recommends using 2 questions that have been validated and tested as part of the Dartmouth Hitchcock Social Determinants of Health questionnaire bundle.⁷

1. What is your housing situation today? (circle one)
 - a. I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, in a park)
 - b. I have housing today but I'm worried about losing housing in the next 90 days
 - c. I have housing
2. In your housing situation, do you have problems with any of the following? (circle all that apply)
 - a. Bug infestation
 - b. Mold
 - c. Lead paint or pipes
 - d. Inadequate heat or hot water
 - e. Oven or stove not working
 - f. No smoker detectors or not working smoke detectors
 - g. Water leaks

Interpreting Results:

- Q1 Answer 1 is positive and indicates homelessness, Answer 2 indicates risk
- Q2 Answers 1-7 are positive and indicate Substandard housing

⁷ Dartmouth Hitchcock Social Determinants of Health screen; Billioux, Alexander, MD, DPhil; Verlander, Katherine, MPH; Anthony, Susan, DrPH; Alley, Dawn, PhD; National Academy of Sciences, "Standardized Screening for Health-Related Social Needs in Clinical Settings - The Accountable Health Communities Screening Tool," <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>

Q1. National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. *The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)* [Internet]. 2016. Available from: www.nachc.org/prapare

Q2. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. "Making the social determinants of health a routine part of medical care." *Health Care Poor Underserved* 2015; 26(2):321–7.

Domain 6: Family and Support Services (Social Isolation)

Region 1 recommends using 1 question that has been validated and tested as part of the Dartmouth Hitchcock Social Determinants of Health bundle.⁸

1. Do you have someone you could call if you need help? (Yes/No)

Interpreting Results:

- “No” is positive and indicates social isolation / lack of support

Region 1 has found that many Partners currently use broad spectrum screens that contain questions that effectively assess the Family & Support Services domain. Some of these screens are proprietary and require fees. To date, Region 1 supports use of the following screening questions:

- Kaiser – Multiple questions that assess social connections
- DLA-20 Q9. Family Relationships
- DLA-20 Q11. Leisure
- DLA-20 Q12. Community Resources
- DLA-20 Q13. Social Network

Domain 7: Education

Region 1 recommends using 1 question that has been validated and tested as part of the Dartmouth Hitchcock Social Determinants of Health bundle.⁹

1. Do you ever need help reading hospital materials? (Yes/No)

Interpreting Results:

- “Yes” is positive and indicates education need

⁸ Dartmouth Hitchcock Social Determinants of Health screen; *National Association of Community Health Centers, Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)*, <http://www.nachc.org/research-and-data/prapare/>

⁹ Dartmouth Hitchcock Social Determinants of Health screen; *HealthLeads* <https://healthleadsusa.org/solutions/tools/>

Domain 8: Employment and Entitlements

Region 1 recommends using 1 question that has been validated and tested as part of the Dartmouth Hitchcock Social Determinants of Health bundle.¹⁰

1. What was your main activity during most of the last 12 months?
 - a. Worked for pay
 - b. Attended school
 - c. Household duties
 - d. Unemployed
 - e. Permanently unable to work
 - f. Other

Interpreting Results:

- “Unemployed” and “Permanently unable to work” are positive and indicates employment/entitlements need

Domain 9: Legal

Region 1 recommends using 1 question that has been validated and tested as part of the Dartmouth Hitchcock Social Determinants of Health bundle.¹¹

1. Do you have any legal issues that are getting in the way of your health or healthcare? (Yes/No)

Interpreting Results:

- “Yes” is positive and indicates Legal assistance need

¹⁰ Dartmouth Hitchcock Social Determinants of Health screen; HealthLeads <https://healthleadsusa.org/solutions/tools/>

¹¹ Dartmouth Hitchcock Social Determinants of Health screen

Domain 10: Risk Assessment Including Suicide Risk

To screen for Interpersonal Safety and Domestic Violence risk, Region 1 recommends using 1 question that has been validated and tested as part of the Dartmouth Hitchcock Social Determinants of Health bundle.¹²

1. In the last 12 months, are you or have you been threatened or abused physically, emotionally or sexually by a partner, spouse or family member? (Yes/No)

Interpreting Results:

- “Yes” is positive and indicates interpersonal safety / domestic violence risk

To screen for suicide risk, Region 1 will provide a suggested screen shortly. Currently Region 1 recommends using question 9 of the PHQ-9.

1. Over the last 2 weeks how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?
 - a. 0-Not at all
 - b. 1-Several days
 - c. 2-More than half the days
 - d. 3-Nearly every day

Interpreting Results:

- 1 or greater is positive and indicates suicide risk

Note that suicide risk is already assessed as question 9 of the PHQ depression screen, if used, and does not need to be duplicated.

¹² Source: Dartmouth Hitchcock Social Determinants of Health screen; Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute. http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

Domain 11: Functional Status

Region 1 recommends using 2 questions from the Medicare Outcomes Survey - ADL & IADL that assess activities of daily living and instrumental activities of daily living:¹³

1. Because of a health or physical problem, do you having any difficulty doing the following activities? (Bathing, Dressing, Eating, Getting in or out of chairs, Walking, Using the toilet, Grooming, No I do not have difficulty with these activities)
2. In the past 7 days, did you need help from others to take care of any of the following activities: (Doing Laundry and housekeeping, Banking, Shopping, Using the telephone, Food preparation, Transportation, Taking your own medications, No I do not have difficulty with these activities)

Interpreting Results:

- “Bathing, Dressing, Eating, Getting in or out of chairs, Walking, Using the toilet, Grooming” are all positive.
- “Doing Laundry and housekeeping, Banking, Shopping, Using the telephone, Food preparation, Transportation, Taking your own medications” are all positive.

Domain 12: Developmental and Behavioral Health screening (Pediatrics)

Region 1 recommends choosing from age-appropriate screening tools validated by the American Academy of Pediatrics to screen for general as well as social emotional development.¹⁴ Note that many of the tools are proprietary and may require a fee:

- AAP has bundled multiple tools as part of the “Bright Futures” for birth through late adolescence.
- Validated general developmental screening tools include:
 - Ages and Stages Questionnaire (ASQ-3)
 - Parents’ Evaluation of Developmental Status (PEDS)
 - Parents’ Evaluation of Developmental Status- Developmental Milestones (PEDS-DM)
 - Brigance Screens
 - Developmental Assessment of Young Children
- Validated social-emotional screening tools include:
 - Ages and Stages Questionnaire: Social-Emotional (ASQ-SE-2)

¹³ Medicare Outcomes Survey - ADL & IADL; Measuring the Activities of Daily Living: Comparisons Across National Surveys, Office of The Assistant Secretary for Planning and Evaluation

¹⁴ American Academy of Pediatrics Bright Futures information may be found at AAP website:

<https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/default.aspx>

American Academy of Pediatrics validated screening tools may be found at the AAP website: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx>

Response to Positive Screens

IDN-1 recommends four pathways in response to positive screens:

1. Immediate Response
2. Brief Intervention and Referral to Treatment (SBIRT Model)
3. Brief Intervention and Referral to Supports (SBIRT Variant)
4. Enhanced Care Coordination

The following table maps the domains to the recommended response pathways:

Table 6: Domains and Response Pathways for Positive Screens

Domain	Response Pathway
Risk assessment including suicide risk	Immediate Response
Depression	Brief Intervention and Referral to Treatment
Substance Use	
Medical	
Functional status	
(Pediatrics) Developmental and Behavioral Health screening	
Housing	Brief Intervention and Referral to Supports
Family & Support Services	
Education	
Employment and Entitlement	
Legal	
Positive Screens in Multiple Domains with Complex Coordination Needs	Enhanced Care Coordination

Response Pathway 1: Immediate Response

Region 1 recommends that Partners utilize current or develop new response protocol for positive screens for Interpersonal Safety and Suicide Risk.



Protocols typically include the following:

1. Timely connection of at risk individual with support (e.g., Suicide watch, help line, domestic abuse shelter, law enforcement)
2. Timely intervention for further assessment of the risk (e.g., Assessment of suicide ideation)
3. Definition of periodic follow up actions
4. Adaptation of protocol for electronic screening that occurs outside of the office visit (e.g., Via a patient portal prior to scheduled appointment)

Response Pathway 2: Brief Intervention and Referral to Treatment

Region 1 recommends that Partners develop workflows based on the “Screening, Brief Intervention, and Referral to Treatment” or SBIRT model developed by the Substance Abuse and Mental Health Services Administration (SAMHSA).¹⁵



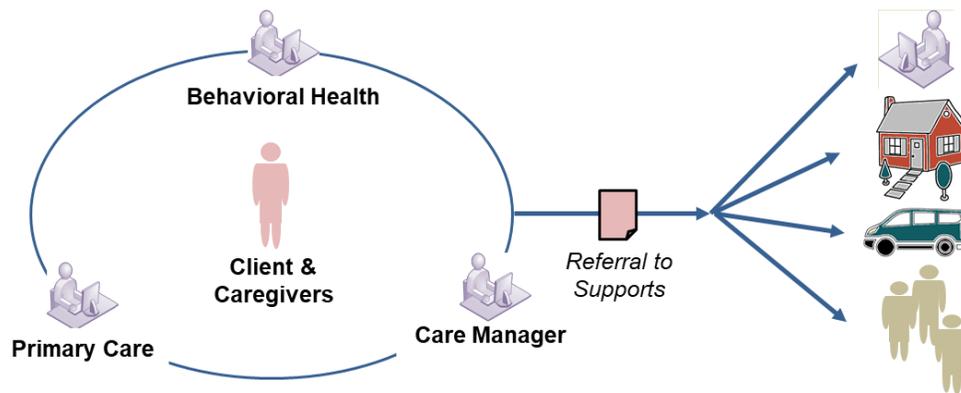
1. Partners should define how positive screens are identified, who in the office will conduct the brief intervention, and how this is documented.
2. Partners should define workflows for referrals to other providers. Referrals may be conducted through a variety of channels. Region 1 encourages Partners to use Direct Secure Messaging and is funding technology and technical support to expand this capability across the region.
3. Partners are specifically measured for follow up to positive depression and/or substance use screens. These measures require presence of a follow up plan. The follow up plan should be documented discretely for easy measurement and reporting.

¹⁵ Substance Abuse and Mental Health Services Administration (SAMHSA) Screening, Brief Intervention, Referral to Treatment, <https://www.samhsa.gov/sbirt>

Response Pathway 3: Brief Intervention and Referral to Supports

Region 1 recommends that Partners develop workflows for Referral to Supports.

1. Partners should define how positive screens for Social Determinants of Health are identified, who in the office will conduct the brief intervention, and how this is documented.
2. Partners should define workflows for locating and referring to Community Supports organizations. Referrals may be conducted through a variety of channels. Region 1 encourages Partners to use Direct Secure Messaging and is funding technology and technical support to expand this capability across the region.



Response Pathway 4: Enhanced Care Coordination

Region 1 recommends that Partners develop workflows to connect Medicaid Members with complex coordination needs Enhanced Care Coordination.

1. Partners should determine eligibility criteria for Members to receive a high level of care coordination support.
2. Partners should use the CCSA as one entry point for enhanced care coordination programs.
3. Partners should map the workflows from screening through to enhanced care coordination including identifying who within the office will conduct the activities.
4. Region 1 is providing a Shared Care Plan platform to support Care Coordination communication and documentation.

Appendix A: Adult (age 18+) CCSA Questions, Survey Logic, and Interpretation

Demographics

Import demographic fields from medical record -or- collect standard fields:

1. Name
2. Address
3. Phone Number(s)
4. Date of Birth
5. Medical Record Number (if used)
6. OPTIONAL: For stronger identity matching among healthcare organizations that see the same Member, consider including:
 - a. Mother's Maiden name
 - b. Patient Alias
 - c. SSN
 - d. Driver's license identifier
 - e. Birth Place
 - f. Multiple Birth (twin, triplet) indicator and birth order.
7. OPTIONAL: For public health measurement purposes it is recommended that Partners gather demographic information questions relevant to health access disparities at the option of the Medicaid Member including:
 - a. Sex/Gender
 - b. Race
 - c. Ethnicity
 - d. Primary Language
 - e. Marital Status
 - f. Citizenship
 - g. Veterans Military Status
 - h. Nationality

Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems:

1. Little interest or pleasure in doing things? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)
2. Feeling down depressed or hopeless? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)

STOP: If sum of scores on question 1-2 => 3, then proceed to Questions 3-9, else proceed to the next section.

3. Trouble falling or staying asleep or sleeping too much? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)
4. Feeling tired or having no energy? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)
5. Poor appetite or overeating? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)
7. Trouble concentrating on things such as reading a newspaper or watching television? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)
8. Moving or speaking so slowly that people noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)
9. Thoughts that you would be better off dead or of hurting yourself in some way? (0=Not at all, 1=Several Days, 2=More than half the days, 3=Nearly every day)

INTERPRETATION: If sum of scores on question 1-9 => 10, then screen is positive for depression. If score on question 9 =>1, then trigger intervention protocol for suicide prevention.

Substance Use – Alcohol

1. How often do you have a drink containing alcohol? (0=Never, 1=Monthly or less, 2=2-4 times per month, 3=2-3 times per week, 4=4 or more times per week)
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0=1-2, 1=3-4, 2=5-6, 3=7-9, 4=10 or more)
3. How often do you have six or more drinks on one occasion? (0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily)

STOP: For Women [or those who were born female and no longer identify with this gender], If sum of scores on question 1-3 => 3, then proceed to Questions 4-10, else proceed to the next section. For Men [or those who were born male and no longer identify with this gender], If sum of scores on question 1-3 => 4, then proceed to Questions 4-10, else proceed to the next section.

4. How often during the last year have you found that you were not able to stop drinking once you had started? (0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily)
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily)
6. How often in the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily)
7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily)
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0=Never, 1=Less than monthly, 2=Monthly, 3=Weekly, 4=Daily or almost daily)
9. Have you or someone else been injured because of your drinking? (0=No, 2=Yes, but not in the last year, 4=Yes during the last year)
10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down? (0=No, 2=Yes, but not in the last year, 4=Yes during the last year)

INTERPRETATION: If sum of scores on question 1-10 => 6, then screen is positive for alcohol misuse.

Substance Use – Drugs

In the past 12 months...

1. Have you used drugs other than those required for medical reasons? (0=No, 1=Yes)

STOP: If score on question 1 =1, then proceed to Questions 2-10, else proceed to the next section.

2. Do you use more than one drug at a time? (0=No, 1=Yes)
3. Are you always able to stop using drugs when you want to? (if never use drugs, answer “Yes”) (0=No, 1=Yes)
4. Have you had “blackouts” or “flashbacks” as a result of drug use? (0=No, 1=Yes)
5. Do you ever feel bad or guilty about your drug use? (if never use drugs, choose “no”) (0=No, 1=Yes)
6. Does your spouse (or parents) ever complain about your involvement with drugs? (0=No, 1=Yes)
7. Have you neglected your family because of your use of drugs? (0=No, 1=Yes)
8. Have you engaged in illegal activities in order to obtain drugs? (0=No, 1=Yes)
9. Have you ever experienced withdrawal symptoms (felt sick when you stopped taking drugs)? (0=No, 1=Yes)
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? (0=No, 1=Yes)

INTERPRETATION: If sum of scores on question 1-10 => 6, then screen is positive for drug misuse.

Medical

1. How is your health? (0=Excellent, 1=Very Good, 2=Good, 3=Fair, 4=Poor)

“Fair” and “Poor” are positive scores

INTERPRETATION: If score on question 1 => 3, then screen is positive for medical issues.

Housing

1. What is your housing situation today? (Multiple choice)
 - a. I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
 - b. I have housing today, but I am worried about losing housing in the next 90 days
 - c. I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
 - a. Bug infestation
 - b. Mold
 - c. Lead paint or pipes
 - d. Inadequate heat
 - e. Oven or stove not working
 - f. No or not working smoke detectors
 - g. Water leaks
 - h. None of the above

INTERPRETATION: If question 1a, then screen is positive for homelessness. If question 1b, then screen is positive for risk of homelessness. If question 2a-g, then screen is positive for substandard housing.

Family & Support Services

1. Do you have someone you could call if you need help? (Yes/No)

INTERPRETATION: If question 1 = No, then screen is positive for social isolation / lack of support

Education

1. Do you ever need help reading hospital materials? (Yes/No)

INTERPRETATION: If question 1 = Yes, then screen is positive for education need.

Employment and Entitlement

1. What was your main activity during most of the last 12 months? (Worked for pay, Attended school, Household duties, Unemployed, Permanently unable to work, Other)

INTERPRETATION: If question 1= “Unemployed” or “Permanently unable to work,” then screen is positive for employment/entitlements need.

Legal

1. Do you have any legal issues that are getting in the way of your health or healthcare? (Yes/No)

INTERPRETATION: If question 1= “Yes,” then screen is positive for legal need.

Risk assessment – Domestic Safety/Abuse

1. In the last 12 months, are you or have you been threatened or abused physically, emotionally or sexually by a partner, spouse or family member? (Yes/No)

INTERPRETATION: If question 1= “Yes,” then screen is positive for domestic safety risk/ abuse.

Functional status

1. Because of a health or physical problem, do you having any difficulty doing the following activities? (check all that apply)
 - a. Bathing
 - b. Dressing
 - c. Eating
 - d. Getting in or out of chairs
 - e. Walking
 - f. Using the toilet
 - g. Grooming
 - h. No I do not have difficulty with these activities
2. In the past 7 days, did you need help from others to take care of any of the following activities: (check all that apply)
 - a. Doing Laundry and housekeeping
 - b. Banking
 - c. Shopping
 - d. Using the telephone
 - e. Food preparation
 - f. Transportation
 - g. Taking your own medications
 - h. No I do not have difficulty with these activities

INTERPRETATION: If question 1= “Yes” for “Bathing, Dressing, Eating, Getting in or out of chairs, Walking, Using the toilet, Grooming,” -or- If question 2= “Yes” for “Doing Laundry and housekeeping, Banking, Shopping, Using the telephone, Food preparation, Transportation, Taking your own medications,” then screen is positive for functional status.

B1.8a Pediatric CCSA Utilization

Given the phased rollout of the B1 partners in IDN1, the implementation of the Pediatric CCSA is moving secondary to the Adult CCSA. IDN1 participated in discussions at D-H regarding the use of the Dartscreen as fulfillment of the required Pediatric CCSA domains, and used this work as the foundation to support development of IDN1 guidance for Pediatric and Adolescent screening. Additionally, conversations are underway with Newport Health Center to review their existing Pediatric screening to use in their onboarding B1 project.

Utilization January 1, 2018-June 30, 2018		
	Validated Universal Screening: ASQ:3, and /or ASQ SE at 9, 18, 24/30 month pediatric visits	Developmental Screening using Bright futures or other American Academy of Pediatrics recognized development tools
Providers		
Alice Peck Day Primary Care	Anticipated utilization after launch- projected not later than October, 2018	
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care	Y	Y
Dartmouth-Hitchcock Heater Road Primary Care Practices	Y	Y
Dartmouth-Hitchcock Psychiatry	Y	Y
Monadnock Family Services	Deployment underway	
New London Hospital and Medical Group Practice, Pediatric Primary Care Practice, Newport Health Center Pediatric Practice	Deployment underway	
Valley Regional Hospital Primary Care Practice	Deployment underway	
West Central Behavioral Health	Y	Y
Counseling Associates	Pending Expansion	

B1.8b Multi-Disciplinary Care Team Members by Practice

Given the phased rollout of the B1 projects and varied implementation flow of each practice team the development of the MDCT across practices is continually in process. The DH-HRS/WCBH team began meeting with their MDCT in spring of 2018 and have held 4 sessions of the group. The team is operating within a rapid cycle PDSA to review the established MDCT referral flow, in meeting workflow and follow up linked to the closed loop referral process. Those practices listed in gray below have not yet completed hiring for the needed MDCT staffing.

Providers	Multi-Disciplinary Core Team Members		
	Primary Care Staff Role	Behavioral Health Staff Role	Case Manager Staff Role
Dartmouth- Hitchcock Heater Rd. South Primary Care Practice, Dartmouth Hitchcock Psychiatry, West Central Behavioral Health			
<i>Practice Team 1</i>	PCP, MA	BHC	CTC
Dartmouth-Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services			
<i>Practice Team 1</i>	PCP, MA	BHC	CTC
<i>Practice Team 2</i>	PCP, MA	BHC	CTC
Valley Regional Hospital Based Primary Care and Counseling Associates			
Practice Team 1	PCP, MA	BHC	CTC
Alice Peck Day Primary Care	PCP, MA	BHC	CTC
New London Hospital and Medical Group Practice and Pediatric Practice, Newport Health Center Pediatric Practice	PCP, MA	BHC	CTC
Monadnock Hospital Primary Care- Peterborough Practice	PCP, MA	BHC	CTC

B1-8c. Required Training

Commencing in January, 2018 the IDN1 team began embedding required 15-30 min trainings at the start of our monthly Knowledge Exchange sessions and supporting external trainings for IDN1 partners with an emphasis on B1 teams. For the KE sessions direct project attendance is not tracked just the aggregate number of attendants' month over month. However, the vast majority of the trainings offered in IDN1 are recorded and put on the IDN1 website along with supporting documents (please see A1-3 for screenshots of training postings). They are then made available to all the IDN1 network partners; all partners and B1 participants, specifically, receive email notifications guiding them directly to the resource. Required trainings covered thus far have been:

- SDoH Questionnaire and Response Review led by Jen Raymond of D-H
- Diabetes, Hyperlipidemia led by Dr. Charlie Brackett of D-H
- Tobacco Cessation and Treatment Options led by Kate McNally, MS, CTTS, of Cheshire Medical Center
- Chronic Disease Management led by Dr. Tracy Tinker of CMC
- Partners in Recovery Wellness: How Hospitals and Recovery Coaches Can Improve Outcomes for Patients with Substance Use Disorder
- Motivational Interviewing- To be held July, 2018 by Christine Powers, LICSW and David Lynde, LICSW

Additionally, IDN1 has supported the following (more details on these trainings in the A1 Section)

- Workforce financing for WCBH to offer 6 series of Mental Health First Aid training to IDN1 partners, two of which were held during this reporting period
- Coordination with IDNs 4, 6 to bring a 2-day Cherokee Health System training to NH, 40+ participants from IDN1 attended
- Coordination with IDNs 5, 7 to offer a full day Addiction 101 training in September open to 40 registrants from IDN1
 - IDN1 has also offered paid slots to network partners for trainings sponsored by different entities such as "Navigating Medicaid Changes for Prevention, Treatment and Recovery" held by the NH Providers Association

The IDN1 team chose to delay the start of trainings in order to build attendance momentum and to allow initial sessions to focus on the pressing topics identified by attendees at the fall 2017 Advisory Council. We will continue to offer IDN sponsored seats and host quarterly trainings throughout the next semi-annual period targeting to continue the KE session trainings and host additional trainings as necessary.

See table below for training status as of 6/30/18:

Providers	Diabetes Hyperglycemia		Dyslipidemia		Hypertension		Mental Health Topics (Multiple)		SUD Topics (Multiple)	
	PC Staff	BH Staff	PC Staff	BH Staff	PC Staff	BH Staff	PC Staff	BH Staff	PC Staff	BH Staff
Dartmouth-Hitchcock Heater Rd. South Primary Care Practice , Dartmouth Hitchcock Psychiatry, West Central Behavioral Health										
<i>Heater Rd Practice Team 1</i>	Attained		Attained		Attained		Attained		Attained	
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services										
<i>Practice Team 1 Located at MFS</i>	Attained		Attained		Attained		Attained		Attained	
<i>Practice Team 2 - Pending</i>	Pending Onboarding									
Valley Regional Hospital Based Primary Care Practices and Counseling Associates										
Practice Team 1	Attained		Attained		Attained		Attained		Attained	
Alice Peck Day Hospital Based Primary Care Practice	Offered		Offered		Offered		Offered		Offered	
New London Hospital and Medical Group Practice, Pediatric Care Practice, Newport Health Center Pediatric Practice	Offered		Offered		Offered		Offered		Offered	
Monadnock Hospital Primary Care- Peterborough Practice	Offered		Offered		Offered		Offered		Offered	

B1-8d. Non Direct Care Staff Training

The Region 1 IDN staff in partnership with the Executive Committee and Project teams have decided that the most valuable application of Mental Health training for non-direct care staff would be targeted at all Billing and Reception staff throughout the B1 organizations. At minimum IDN-1 will support required trainings for both of these staff positions. Due to the current phase of project development, the exact number of staff at each provider site is not yet known. If there is demonstrated need for expanded staffing, the IDN will support additional trainings. In the instance an IDN partner requests training for other staff categories the IDN will support this request as well. The Region 1 team plans to cover domain areas aligned with Mental Health First Aid training in a high level 30-45-minute web-based training that will be recorded and disseminated to all applicable staff throughout the wave implementation process.

If a provider expresses interest in expanded training, or requires additional information in any of the domain areas, the Region 1 IDN team will facilitate more robust either online or in-person. As of June 30, 2018 the IDN staff is continuing to explore alternative options for non-direct-care staff training and

expects to leverage some of the IDN KE and large partner meetings as a location to offer these trainings. As above, these trainings will be recorded and made available to partners on the IDN website.

	July 1, 2017- December 31, 2017	January 1, 2018-June 30, 2018	July 1, 2018- December 31, 2018
Providers			
Dartmouth-Hitchcock Heater Rd. South Primary Care Practice , Dartmouth Hitchcock Psychiatry, West Central Behavioral Health			
<i>Heater Rd Practice Team 1</i>	Training Completed	Training Completed	
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services			
<i>Practice Team 1</i>	Pending MFS Site Launch		
Valley Regional Hospital Based Primary Care Practices and Counseling Associates			
Practice Team 1	Pre-Project Launch	In Process	
Alice Peck Day Hospital Based Primary Care Practice	Pre-Project Launch	Pre-Project Launch	
New London Hospital and Medical Group Practice, Pediatric Care Practice, Newport Health Center Pediatric Practice	Pre-Project Launch	Pre-Project Launch	
Monadnock Hospital Primary Care-Peterborough Practice	Pre-Project Launch	Pre-Project Launch	

B1-8e. Multi-Disciplinary Core Team Schedule

Please note that due to the current stage of project implementation there is no schedule for any provider team other than the DH/WCBH and VRH/CA Teams.

As noted above these projections for provider launch dates are not firm, and are subject to change. If there are applicable changes to the MDT schedule these will be noted and corrected on subsequent Semi-Annual Report submissions.

All B1 MDTs will meet the minimum requirements for monthly meetings. IDN-1 anticipates that many of the B1 project will, in fact, meet more frequently than the monthly requirements, for both informal case conferencing and to address implementation barriers with the QI facilitators and IDN1 Program Director.

	July 1, 2017- December 31, 2017	January 1, 2018- June 30, 2018	July 1, 2018- December 31, 2018
Providers			
Dartmouth-Hitchcock Heater Rd. South Primary Care Practice , Dartmouth Hitchcock Psychiatry, West Central Behavioral Health			

<i>Heater Rd Practice Team 1</i>	Project Team Meeting: 2nd, 4th Thursday	Project Team Meeting: 2nd, 4th Thursday , MDCT Meets 2nd Thursday	
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services			
<i>Practice Team 1</i>	Pre-Project Launch	Project Team Meeting: 1st, 3rd Wednesday	
Valley Regional Hospital Based Primary Care Practices and Counseling Associates			
Practice Team 1	Full Project Team Meeting: 2nd, 4th Tuesday , Steering Committee Meeting: 1st, 3rd Tuesday	Full Project Team Meeting: 2nd, 4th Tuesday , Steering Committee Meeting: 1st, 3rd Tuesday	
Alice Peck Day Hospital Based Primary Care Practice	Pre-Project Launch	Pre-Project Launch	
New London Hospital and Medical Group Practice, Pediatric Care Practice, Newport Health Center Pediatric Practice	Pre-Project Launch	Pre-Project Launch	
Monadnock Hospital Primary Care- Peterborough Practice	Pre-Project Launch	Pre-Project Launch	

B1-8f. Secure Messaging

IDN-1 has identified Direct Secure Messaging as one channel for secure communication among Partner organizations. We are providing technical support to Partners to encourage the use of Direct Messaging capabilities that are native to their electronic health record systems. We are providing (at no cost to Partners) Direct Messaging webmail applications in cases where EHR systems are not capable of supporting Direct Messaging. Webmail applications are provided by the vendor Kno-2 and all contracting, payment, training, and support components are in place for Partners who wish to access this technology.

As of June 30, 2018, 12 IDN-1 Integrated Care Participants were capable of exchanging Direct Secure Messages. This represents 57% of the overall target of 21 organizations connected to Direct Messaging. On the community side, 6 IDN-1 Supporting Partners were capable of exchanging Direct Secure Messages. This represents 67% of the overall target of 9 organizations.

IDN-1 is finding that uptake of Direct Secure messaging remains stagnant in this reporting period. While the projects are improving clinician to clinician communication among Partner organizations, clinicians are not easily adopting the DSM capabilities that are available in their EHRs to share information. This is consistent with uptake of this technology nationally.

As we stated in our last report, IDN-1 remains flexible with regards to Direct Messaging. Our overarching goal is to support inter-organizational communication for purposes of improved care coordination. We will continue to push Direct Messaging as our preferred technology. Use of legacy communication channels (e.g., Fax, Mail) are not ideal but acceptable to the IDN as long as communication and coordination are improving, and thus, positively impacting patient care. Use of emerging communication channels (e.g., Care Everywhere, CommonWell) are expected to eventually supplant Direct Messaging as

the preferred standard for electronic communication and we look forward to helping our partners evolve with improving technology.

B1-8g. Closed Loop Referrals (CLRP)

The Integrated Care Team will interface with the Community Based Support Services organizations through a formal closed-loop referral process. The Care Team Coordinator will be the accountable member of the Integrated Care Team in all communications with the Community Based Support Services. Upon identification of a need for community support services by the Integrated Care Team, the Care Team Coordinator will begin the referral to supports process.

Where the provider of supports is not known by the team, the Care Team Coordinator will work with Care Navigation resources to identify appropriate and available community supports. This may take the form of a care navigation organization such as ServiceLink or by using one of the care navigation data assets available in the region.

NH Alcohol and Drug Treatment Locator (<http://nhtreatment.org/>)

Refer Web - Servicelink Community Resource Directory (<http://www.referweb.net/nhsl/>)

NH Easy – Gateway to Services (<https://nheasy.nh.gov/#/>)

NH Peer Support by region: (<http://www.dhhs.nh.gov/dcbcs/bbh/peer.htm>)

2-1-1 New Hampshire and <http://www.homehelpnh.org/> for housing assistance

Monadnock Regional Council for Community Transportation (<http://monadnockrcc.weebly.com/need-a-ride.html>) (other regions <https://www.nh.gov/dot/programs/scc/rcc.htm>)

The Care Team Coordinator will initiate a referral to the Community Based Support Service and transfer all pertinent information. This will be facilitated via secure Direct Secure Message. Where EHRs are capable of initiating a referral over Direct, the EHR will be used. Where EHRs are incapable of initiating a referral, a Webmail will be used to send the referral to support. Community Support Services organizations will receive the referral to supports via a Direct Messaging Webmail inbox. As the process is being first implemented, the Care Team Coordinator will also follow up via phone to ensure that the Community Support Services organization is aware of the referral and is following up appropriately.

To complete the “closed loop” referral, the Community Based Support Service organization will acknowledge receipt of the referral, will inform the Care Team Coordinator of patient engagement with the services, and will provide updates periodically. The Care Team Coordinator will actively query Community Support Services Providers to follow up on “open” referrals.

Updates as of January-June, 2018:

- **Given the slow development of the SCP use and other technology platforms across the implementing B1 project partners the IDN1 team has issued guidance on the minimum requirement for Closed Loop Referrals based off of the framework above. With each project team uniquely taking on the challenge of referral and information sharing the IDN is supporting tailor ability of each CLRP by project team.**

- Once projects have moved farther along and there is additional evidence to support the functionality of the B1 pilot’s workflows and processes around CLRPs the IDN will amend the above to a guidance document, protocol for CLRP development.

B1-8h. Documented Workflows and/or Protocols:

The following workflows and protocols have been supported by the Region 1 IDN team and will be shared with all B1 providers as potential operating pathways to follow. Our continued process will allow for some trial and flexibility with additional workflows or new protocols within a practice team if the case can be made for the potential benefit to the implementation processes.

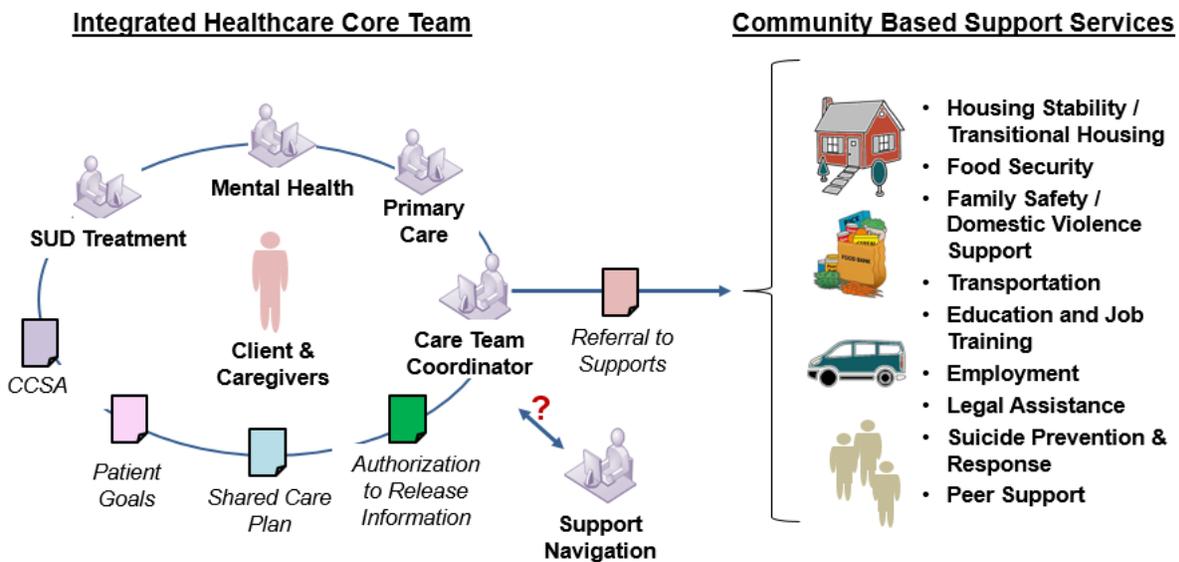
Updates as of June 30, 2018:

The IDN1 Administrative team is collaborating with the active B1 project partners and with the other IDN regions to vet the documented workflows and protocols for usability. The IDN1 team will concisely outline all workflow and protocol recommendations into guidebooks following the framework of the CCSA protocol (included above) to share with all project partners in late fall/early winter, 2018.

Interactions between providers and community based organizations

The Integrated Healthcare Core Team will use a formal closed-loop referral process to connect Medicaid Members with Community Based Organizations. The following protocol defines population to be served, support teams, communication process and supporting technology.

Figure 12: Integrated Care Delivery Model



Population to be served:

NH Medicaid Beneficiaries with Behavioral Health Conditions or at risk for such conditions. Population is to be divided into three groups:

High Needs Members: Members that are high utilizers of area Emergency Departments and/or who have (or at risk of having) complex medical, behavioral health, and social determinants needs.

- IDN1 is allowing project teams to add additional high acuity criteria based on their immediate team needs to determine MDCT patient selection

Medium Needs Members: Members that have Behavioral Health Conditions and who have (or at risk of having) moderately complex medical, behavioral health, and/or social determinants needs.

Low Needs Members: Members that have Behavioral Health Conditions and who have low complexity medical, behavioral health, and/or social determinants needs.

The teams will focus on the high needs Medicaid Members as they transform care practice. Once new processes are established with this group they will be extended to the Medium Needs Members. Additionally, for those pilot teams beginning with shared pre-existing patients between the primary BH site and PC teams the initial patient identification is often further constrained by these filters as well to carve out a narrow population pool. The IDN is supported the organic development and growth of these small population pilots through the biweekly project team meetings.

Note: These categorizations are to aid in prioritization – Members will likely move upward or downward in need over time

Support Team

The Support Team is made up of the Medicaid Member and her/his Caregivers, an Integrated Healthcare Team, and Community Based Support Services:

Care is centered upon the Medicaid Member and her/his Caregivers

The Integrated Healthcare Core Team is comprised of representatives from a Medicaid Member’s Primary Care Provider, Mental Health Provider, Substance Use Disorder Provider (where applicable), and Care Team Coordinator.

The Community Based Support Services are comprised of organizations that can address a wide array of social determinants of health. These may include, but are not limited to, support services for:

- Housing Stability / Transitional Housing
- Food Security
- Family Safety / Domestic Violence Support
- Transportation
- Education and Job Training
- Employment
- Legal Assistance
- Suicide Prevention & Response
- Substance use treatment
- Peer Support

Collaboration

The Integrated Delivery Team will follow the SAMHSA Six Levels of Collaboration framework and the corresponding definitions of Coordinated Care Practice and Integrated Care Practice from DHHS to guide intra-team communication. The organizations will establish their baseline current level of collaboration utilizing the Citizens’ Health Initiative assessment tool-- the Site Self-Assessment or SSA. With ongoing coaching from the CHI Team, the Integrated Care Team will improve collaboration and communication over the waiver period.

Figure 13: SAMHSA Six Levels of Integration

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> » Have separate systems » Communicate about cases only rarely and under compelling circumstances » Communicate, driven by provider need » May never meet in person » Have limited understanding of each other's roles 	<ul style="list-style-type: none"> » Have separate systems » Communicate periodically about shared patients » Communicate, driven by specific patient issues » May meet as part of larger community » Appreciate each other's roles as resources 	<ul style="list-style-type: none"> » Have separate systems » Communicate regularly about shared patients, by phone or e-mail » Collaborate, driven by need for each other's services and more reliable referral » Meet occasionally to discuss cases due to close proximity » Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> » Share some systems, like scheduling or medical records » Communicate in person as needed » Collaborate, driven by need for consultation and coordinated plans for difficult patients » Have regular face-to-face interactions about some patients » Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> » Actively seek system solutions together or develop work-a-rounds » Communicate frequently in person » Collaborate, driven by desire to be a member of the care team » Have regular team meetings to discuss overall patient care and specific patient issues » Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> » Have resolved most or all system issues, functioning as one integrated system » Communicate consistently at the system, team and individual levels » Collaborate, driven by shared concept of team care » Have formal and informal meetings to support integrated model of care » Have roles and cultures that blur or blend

Source: Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

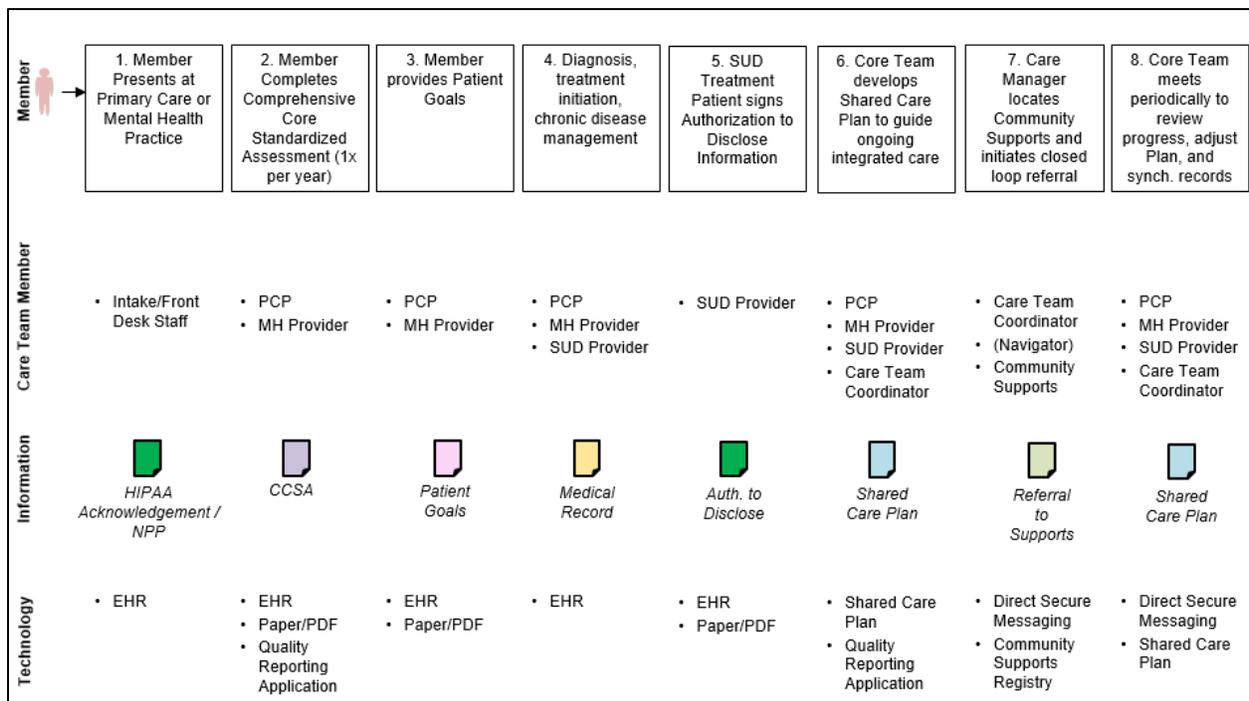
Integrated Care Team Process Flow

The Integrated Care Team will follow the process outlined below for interactions among the Integrated Core Team and with Community Supports Services organizations. This process flow diagram shows the Medicaid Member activities, the associated care team members supporting the Member, the information required at each step, and the technology supporting capture and exchange of the information. The same process applies whether in a primary care setting or a community mental health center. The Integrated Core Team will institutionalize this process flow in the first 6 months of the project rollout and will refine the process with learning and feedback.

Updates as of January-June, 2018:

- **PDSA underway at VRH and DH-HRS for the ICT Process Flow**

Figure 14: Integrated Care Team Process Flow



Shared Care Plan

The Integrated Care Team will utilize a Shared Care Plan in conjunction with each organization’s electronic health record (EHR) to capture, share, and periodically update the following information:

- Care coordination instructions
- Patient Goals
- Shared Plan of Care informed by
- Patient Goals
- Results of Comprehensive Core Standardized Assessment
- Other relevant history from the Medicaid Member’s Medical Records

The Shared Care Plan is a novel concept and is not well supported nationally with standards or conventions. Therefore, the B1 project participants will develop an initial convention for the shared care plan in the first 6 months of the project and will continuously improve the convention thereafter. To avoid fragmentation and lack of standardization, the participants will develop the convention transparently and with support and input from the Data & IT Workgroup and with invitation to share with teams from the other IDNs.

Updates as of January-June, 2018:

- *The DH-HRS/WCBH team has developed a robust workflow regarding the identification of patients for an SCP, development and review of the SCP, patient input on the SCP goals, and workflows around the MDCT review of the SCP.*
 - *The IDN1 team anticipates a bundle of materials sharing these developed processes to be shared with other B1 teams not later than end of summer, 2018.*
 - *These materials will be used in the formal development of the IDN guidance for Shared Care Planning.*

- *The VRH/CA team has expanded on the SCP framework and put in place a FAQ document for their project partners. The IDN1 team will look to include relevant components of this work in their SCP protocol.*

Timely communication

The Integrated Core Team will institute a framework for timely communication in the first 6 months of the project rollout and will refine actions and timing with learning and feedback. The initial framework for timely communication is as follows:

Updates as of January-June, 2018:

- *Currently, no update to the following communication guidelines. The IDN1 team is working with each implementing pilot team to address the feasibility of these targets and identify their gold standard of care. Subsequent reporting sections will include a guideline based protocol for timely communication.*

Action	Timing
Capture (or Update) EHR and Shared Care plan application (CMT) with Care Plan	Within 1 business days of integrated core team shared care meeting.
Initiate Referral to Supports (Care Team Coordinator)	Within 2 business days of integrated core team shared care meeting.
Close the loop by acknowledging Referral of Supports (Community Support Services Organization)	Within 4 hours of message receipt
For “open referrals” Close the loop by contacting the Community Support Services Organization to confirm referral receipt (e.g., by Phone, or SMS)	Within 1 business day of message sent
For all referrals close the loop by Community Support Services Organization to confirm that Medicaid Member utilized services	Within 10 business days of message sent

Privacy, including limitations on information for communications with treating provider and community based organizations

Patient privacy protection is required for all workflows implemented under the NH 1115 waiver. Much of the provision of care under the integrated model may be conducted with standard HIPAA policies, processes, and forms. A higher level of privacy protection is required for Medicaid Members engaging in Substance Use Disorder Treatment as dictated by federal 42 CFR part 2.

The Privacy framework is under development among the IDNs with support from the Citizens Health Initiative [REDACTED]. The privacy framework detailed below was developed from the Privacy boot camp sessions that took place over the summer of 2017. Each of the IDN’s have been working to deploy the components below through fall of 2017 and will continue through spring of 2018.

IDN-1 is offering its Partners the following support to implement privacy protections for purposes of inter-organizational shared care planning and for evaluation/quality reporting:

- Guidance and model forms/language from the Citizens Health Initiative
- Privacy guardrails for conducting shared care planning and evaluation/quality reporting
- Data sharing agreements
- Privacy seminars, webinars, and individual meetings
- Access to legal advisory support [REDACTED]

Updates as of January-June, 2018:

- *The IDN1 team has worked closely with WCBH to develop a workable consent form and process for patient inclusion in the CMT SCP. The lessons learned and examples from this form development will be shared at the upcoming September, 2018 Advisory Council for all IDN1 partners to use as a guide.*
- *The IDN team will release additional guidance in fall, 2018 on lessons learned and privacy options for partners*

Coordination among case managers (internal and external to IDN)

There are multiple case managers who may be involved in a Medicaid Member's health management. These may include Payer/MCO case managers, IDN case managers, and healthcare organization case managers.

IDN-1 is seeking to leverage these case management resources. This will require reducing confusion to Medicaid Members by supporting coordination with the various case managers. This will also require removal of duplicative roles and communication.

The Care Team Coordinator will be accountable for case manager coordination. She/he will determine the case management resources that are to be part of the integrated core team and the case managers who are to be kept informed of the shared care plan.

There is an open question to DHHS regarding the role of the MCO case managers in the NH 1115 waiver activity. Both the IDNs and the MCOs recognize the duplicative roles of their case managers, the potential confusion to and redundancy of health risk assessments for Medicaid Members, and the value in collaboration. We welcome guidance from DHHS on how to include the MCOs in the waiver programs.

Updates as of January-June, 2018:

- *The IDN1 team is working closely with the pilot teams to identify points of coordination with other case management efforts and make the patients inclusion in the MDCT/SCP visible in the EHR. These efforts are ongoing and the process for coordination will continue to be managed on a team by team basis as each of the unique B1 pilots have varying external resources within their catchment areas.*
- *The IDN will build from the team's process work to identify guidance for newly onboarding B1 projects around care coordination.*

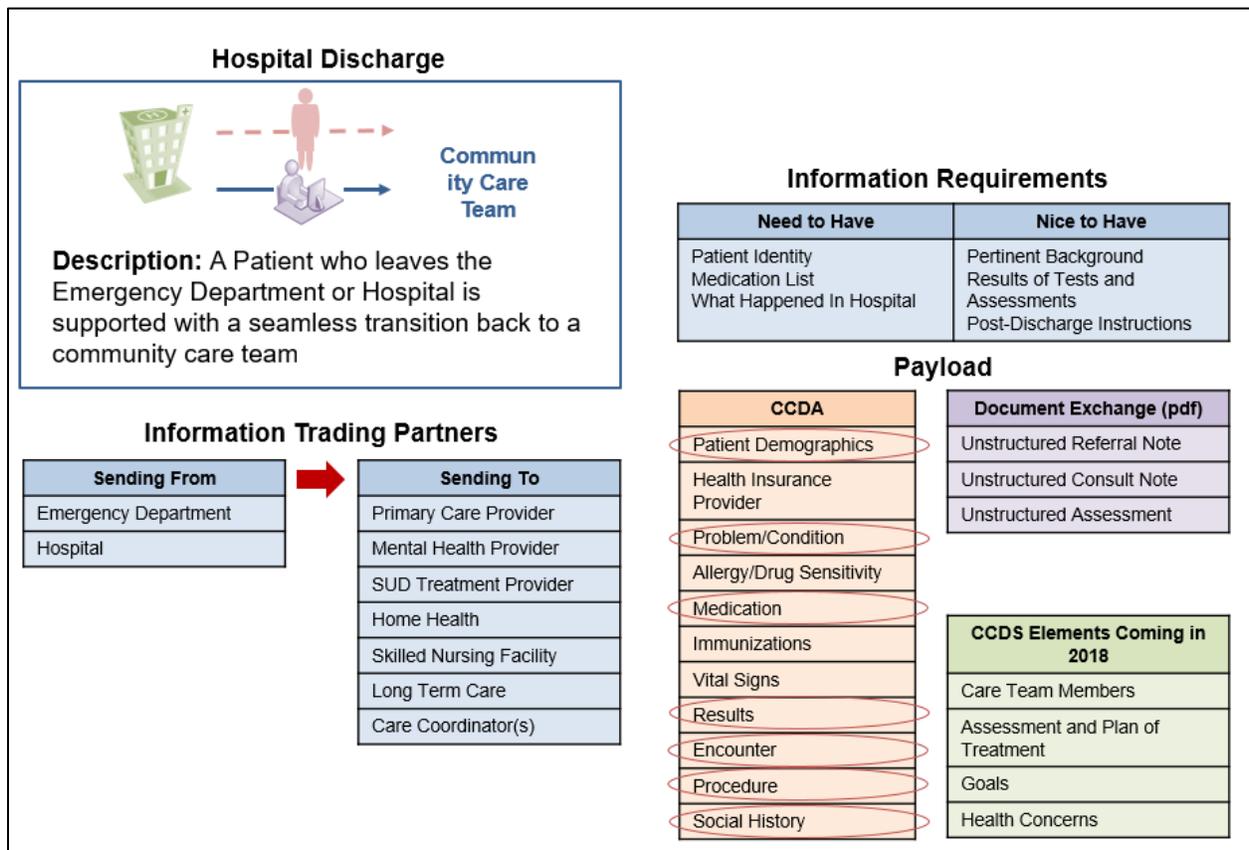
Safe transitions from institutional settings back to primary care, behavioral health and social support service providers

IDN-1 will implement workflows to facilitate safe transitions from institutional settings back to primary care, behavioral health, and social support service providers. The most important pieces of information to accompany the patient are:

- Current medication list – to enable medication reconciliation among all post-acute care providers and to prevent medication based adverse events.
- Recent history of what happened during the hospitalization, any new problems discovered, any procedures undergone, and any new history discovered.
- Instructions for who is to do what in a post-discharge hand-off between healthcare teams.

IDN-1 will use the following workflow for institutional transitions. The underlying technology is explained in project A2.

Figure 15: Institutional/Hospital Discharge Workflows



IDN-1 projects need to have met all standardization requirements for workflows and protocols across the required Integrated Healthcare project not later than summer of 2018. Due to the wavelike nature of project rollout the IDN will support the last onboarding of B1 practices and from there push for a formal adoption of standardized workflows and protocols. Allowing for all partner involvement in this process will be critical to use and adoption, necessitating a longer period to reach standardization.

Updates as of January-June, 2018:

- *Ongoing efforts are underway to align IDN project work with NHH discharge and to streamline the transition points for patients in each of the IDN's 3 sub-regions: Lower Grafton, Sullivan County and the Monadnock Region.*
- *These efforts and IDN level guidance will be shared in the B1 protocols document to be released late fall, 2018.*

Adherence to NH Board of Medicine guidelines on opioid use:

No change to the guidance from July-December, 2017 Submission.

IDN 1 will support all Partners to ensure that their NH Board of Medicine compliance programs are in place for the new guidelines on Opioid use. Recognizing the acuity of the opioid crisis and the newness of the final rules for opioid prescribing adopted by the Board of Medicine on November 2, 2016, IDN-1 will assist Partner organizations to implement the guidelines.

IDN-1 will help inform prescribers of their responsibilities under NH law and the final rule. This includes connecting providers with resources offered by the State Government, the NH Medical Society, and multiple supporting organizations.

Specifically, IDN-1 will promote use of the following resources with Partners that are updating their processes for opioid prescribing:

- NH Board of Medicine Resources: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>
- Final Rule: PART Med 502 Opioid Prescribing:
<https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf>
https://www.nhms.org/sites/default/files/Pdfs/NH_BOM_opioid_rules_11-2-16.pdf
- Board-Approved Risk Assessment Tools: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>
- Training and Continuing Medical Education opportunities:
<https://www.oplc.nh.gov/medicine/opioid-prescribing.htm> <http://www.nhms.org/opioidcme>
- Checklist for the Prescribing of Opioids for the Management or Treatment of Pain.
https://www.nhms.org/sites/default/files/Pdfs/1-4-17Opioid_Patient_Checklist_Med_502_Opioid_Prescribing_Rules.pdf
- New Hampshire Opioid Prescribing Resources from the NH Medical Society:
<https://www.nhms.org/resources/opioid>
- Opioid Dose Calculator from the Agency Medical Directors' Group:
<http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>

IDN 1 will support all practices participating in B1 as they implement prescribing processes and workflows that comply with the NH Board of Medicine opioid prescribing guidelines for both acute and chronic pain conditions. IDN-1 will check with its Partners to be sure programs are in place though formal compliance monitoring will remain a Board of Medicine function.

Updates as of January-June, 2018:

- *The IDN1 team continues to assess current partner sites practices for adherence to the Opioid use guidelines and from this current state understanding will build up MAT adherence in the B1 protocols document.*

Project Scoring: IDN Integrated Healthcare Process Milestones and Achievement of *Coordinated Care Practice* Designation Requirements

DHHS will use the tool below to assess progress made by each IDN’s Integrated Healthcare Implementation Plan activities. Grayed areas indicate that no submission is expected for the time frame. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: <ul style="list-style-type: none"> Demographic information Physical health review Substance use review Housing assessment Family and support services Educational attainment 	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<ul style="list-style-type: none"> • Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT 					
	<p>For pediatric providers, the CCSA must also include:</p> <ul style="list-style-type: none"> • Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; • Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental 	Table listing all providers by domain indicating Y/N on progress for each process detail				
B1-8b	<p>List of multi-disciplinary core team members that includes, at minimum:</p> <ul style="list-style-type: none"> • PCPs • Behavioral health providers (including a psychiatrist) • Assigned care managers or community health worker 	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum:	Training schedule and Table listing all				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<ul style="list-style-type: none"> • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple) 	<p>provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training.</p> <p>OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training</p>				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in	Training schedule and table listing all staff indicating				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	recognition and management	progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> • Interactions between providers and community based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support service providers • Intake procedures that include systematically soliciting patient consent to confidentially share information among providers 	Work flows and/or Protocols (submit all in use)				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<ul style="list-style-type: none"> Adherence to NH Board of Medicine guidelines on opioid prescribing 					

B1-9. Additional Documentation as Requested in B1-9a - 9d

- a. *Achievement of all the requirements of a Coordinated Care Practice*
- b. *Adoption of both of the following evidence-based interventions:*
 - *Medication Assisted Treatment*
 - *Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through the use of IMPACT or other evidence-supported model*
- c. *Use of Technology to identify, at a minimum:*
 - *At Risk Patients*
 - *Plan Care*
 - *Monitor/Manage Patient progress toward goals*
 - *Ensure Closed Loop Referral*
- d. *Documented Workflows including at a minimum: Joint service protocols and Communication channels*

B1-9a. Report on progress toward coordinated care designation

In the first two SAR periods the steps below have been undertaken. Please see updates in italics. Next steps:

1. Complete SSA surveys by fall 2017 : *Completed*
2. Re-define B1 partner implementation waves as needed by 12/31/17: *Completed and Relaunching in March/April, 2018*
3. Engage partners in practice change initiatives starting in October, 2017: *Completed and recurring monthly*
 - o Using Knowledge Exchange sessions to form a cohort of partners
4. Plan for secondary steps to achieve CC status at each practice within 4-6 months of starting its B1 pilot : *Ongoing*
5. *Continued implementation rollout across the IDN1 B1 partners – continuing through Fall, 2018*
6. *Ongoing Shared Care Planning and CSA Trainings/Work Sessions- continuing through Fall, 2018*

B1-9b. MAT

Updates as of June 30, 2018:

The IDN1 Administrative team is collaborating with the active B1 project partners and with the other IDN regions to vet the documented MAT workflows and protocols for usability. The IDN1 team will concisely

outline all workflow and protocol recommendations into guidebooks following the framework of the CCSA protocol to share with all partners in fall, 2018.

MAT and evidence based treatment of mild to moderate depression is currently in practice at the DH Lebanon Heater Rd clinic. MAT protocols are being refined at time of submission.

At time of implementation, through provider meetings and B1 assessments, the IDN has been notified that the following agencies are currently supporting MAT programs:

[Redacted]

Through projects, the IDN team will assess and encourage expanded MAT and support for implementation. The [Redacted]

Updated MAT Involvement in IDN1 January-June, 2018:

- Peter Mason, MD, the Region 1 Medical Director is on the steering committee and participating in a statewide Community of Practice for MAT initiative spearheaded by BDAS, JSI and the Foundation for Healthy Communities.
- Dr. Mason is involved in the development of Addiction 101 curriculum, which includes MAT, designed to be offered to primary care practices throughout NH

The above-mentioned [Redacted]

- The IDN 1 Medical Director has had discussions with practices in Claremont and Keene about expanding MAT.
- Dr. Mason will be a faculty member of the ECHO program, a joint project of CHI and Maine Quality Counts, beginning in September, to support new MAT programs throughout the two states.
- Dr. Mason has done a presentation on MAT in Enfield under the auspices of the Mascoma Valley Community Health Center.
- Dr. Mason has done didactic sessions on MAT at Headrest to help with the integration of MAT and a variety of counseling modalities.

- The IDN1 team will compile current organization and project practices regarding MAT and Depression treatment. These current standards of care will serve as the foundation for the IDN protocol guidance to be released in late fall, 2018.

B1-9c. HIT

Organization	Use of Technology to Identify at Risk Patients - -May Include: -EHR System -Pre-Manage -Quality Data Center -MCO Data	Use of Technology to Plan Care - May Include: -EHR System -Pre-Manage	Use of Technology to Monitor/manage patient progress toward goals - May include: -EHR System -Pre-Manage -Quality Data Center	Use of Technology to Ensure closed loop referral - May include: -Direct Secure Messaging -CommonWell/Carequality -Other Referral Method
Alice Peck Day Primary Care	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Cheshire Medical Center - Primary Care	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Child and Family Services	EHR System: No Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: No Pre-Manage: No	EHR System: No Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Counseling Associates	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Crotched Mountain Community Care	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Dartmouth-Hitchcock Clinic Lebanon	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Dartmouth-Hitchcock Psychiatric Associates	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
MAPS	EHR System: No Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: No Pre-Manage: No	EHR System: No Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Mindful Balance Therapy Center PLLC	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Monadnock Community Hospital - Primary Care	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Monadnock Family Services	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
New Hampshire Hospital	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
New London Medical Group Practice	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
New London Pediatric Care Center Practice	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Newport Health Center Practice	EHR System: Yes Pre-Manage: No Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Phoenix House	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No

Planned Parenthood of Northern New England - Claremont	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Planned Parenthood of Northern New England - Keene	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Southwestern Community Services	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
TLC Family Resource Center	EHR System: No Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: No Pre-Manage: No	EHR System: No Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Valley Regional Hospital, Valley Family Physicians	EHR System: Yes Pre-Manage: No Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
West Central Behavioral Health	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Key:				
Little or no IT capability to support the function.				
Some siloed (single organization) IT capability to support the function.				
Multi-organization IT capability in place to support the function.				

IDN-1 is currently utilizing health information technology to support the B1 projects. Full details of the HIT supporting solutions are detailed in project A2. Four specific areas were identified in B1-9c for detail and are explained below:

Use of Technology to Identify at Risk Patients: IDN-1 is taking a multi-pronged approach to identifying Medicaid Members, and in particular, Members that are at risk patients:

IDN-1 is working with DHHS to receive Medicaid Attribution files to identify the universe of members that fall under the 1115 waiver and the sub-universe of Members with a Behavioral Health indication.

IDN-1 is utilizing Pre-Manage ED to identify patients that are frequent users of area Emergency Departments. Currently the data around ED visits is building, as 3 of 6 hospitals are populating Pre-Manage ED with live encounter data while 1 additional hospital is close to go live. ED use is a strong indicator that patients are at risk and/or have complex care needs.

IDN-1 will utilize the Quality Reporting vendor going forward to identify at risk patients as Medicaid Members that are not meeting measures or that are out of normal ranges for clinical quality outcomes measures.

IDN-1 Partners have been informed of the capabilities of the MCOs for identifying high risk patients. Partners are not yet accessing these MCO services and tools but are being encouraged to do so. Note: We were relying on the MCO's to collaborate on this, as they have a set of reports available that identifies at risk patients, but they have not yet engaged with IDN-1 or with the IDN-1 partners.

IDN-1 Partners are using their EHR systems to identify at risk Medicaid Members through chart review.

Use of Technology to Plan Care: IDN-1 is using multiple technologies to plan care:

IDN-1 Partners are using the patient medical record housed in the EHR as the primary care plan.

IDN-1 Partners are beginning to use the Shared Care Plan platform provided by the vendor CMT to document a plan of care that may be shared with the Core Integrated Health team across multiple organizations.

Care plans are informed by:

Patient medical records housed in the EHRs

Patient Goals – housed in the EHRs and Shared Care Plan

Comprehensive Core Standardized Assessment – housed in the EHRs and in document form.

Use of Technology to Monitor/manage patient progress toward goals: IDN-1 is utilizing multiple technologies to monitor and manage patient progress toward goals:

Patient goals are housed in the EHR and in the shared care plan

Partners use the patient medical record housed in the EHR as the primary record for patient progress tracking.

Partners are beginning to use the Shared Care Plan platform provided by the vendor CMT to document and periodically update a shared plan of care.

Progress of patients at the population level will be tracked in the quality data reporting platform.

Use of Technology to Ensure closed loop referral: IDN1 continues to monitor emerging technologies for closed loop referrals, including Commonwell, Carequality and emerging referral technologies (e.g. UniteUs, e.g. Quartet Health).

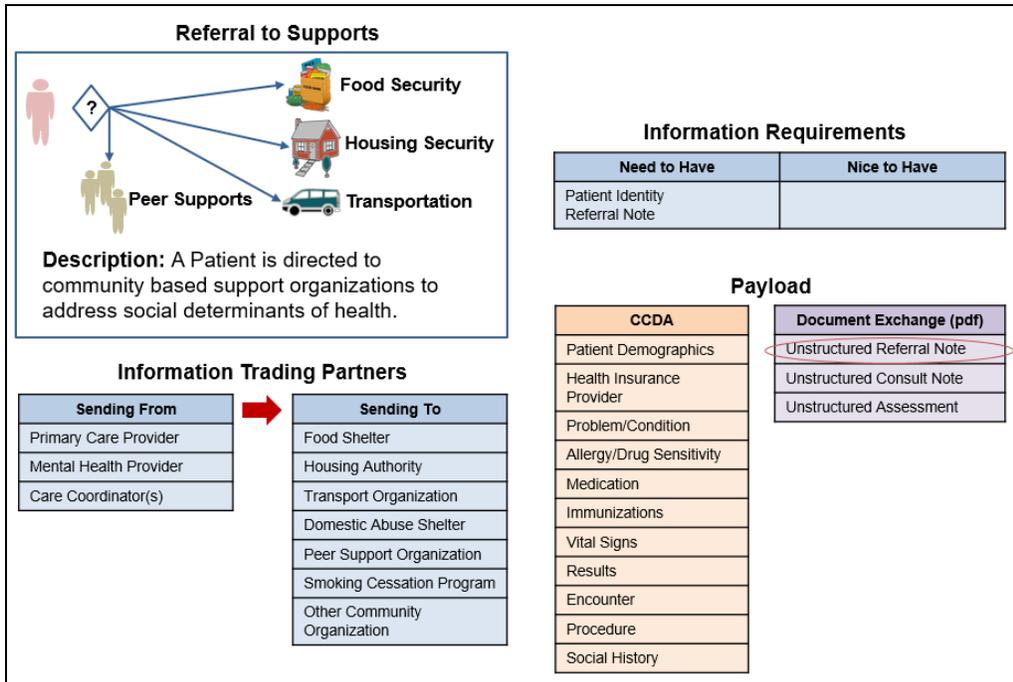
B1-9d. Joint Service Protocols and Communication Channels

IDN-1 will support a formal bi-directional referral process when jointly serving patients with community based social support services organizations. There are two primary workflows:

Referral to Supports

This is a formal closed loop referral from a medical provider to a community supports organization that is used to initiate, acknowledge, and follow up on supports that address social determinants of health.

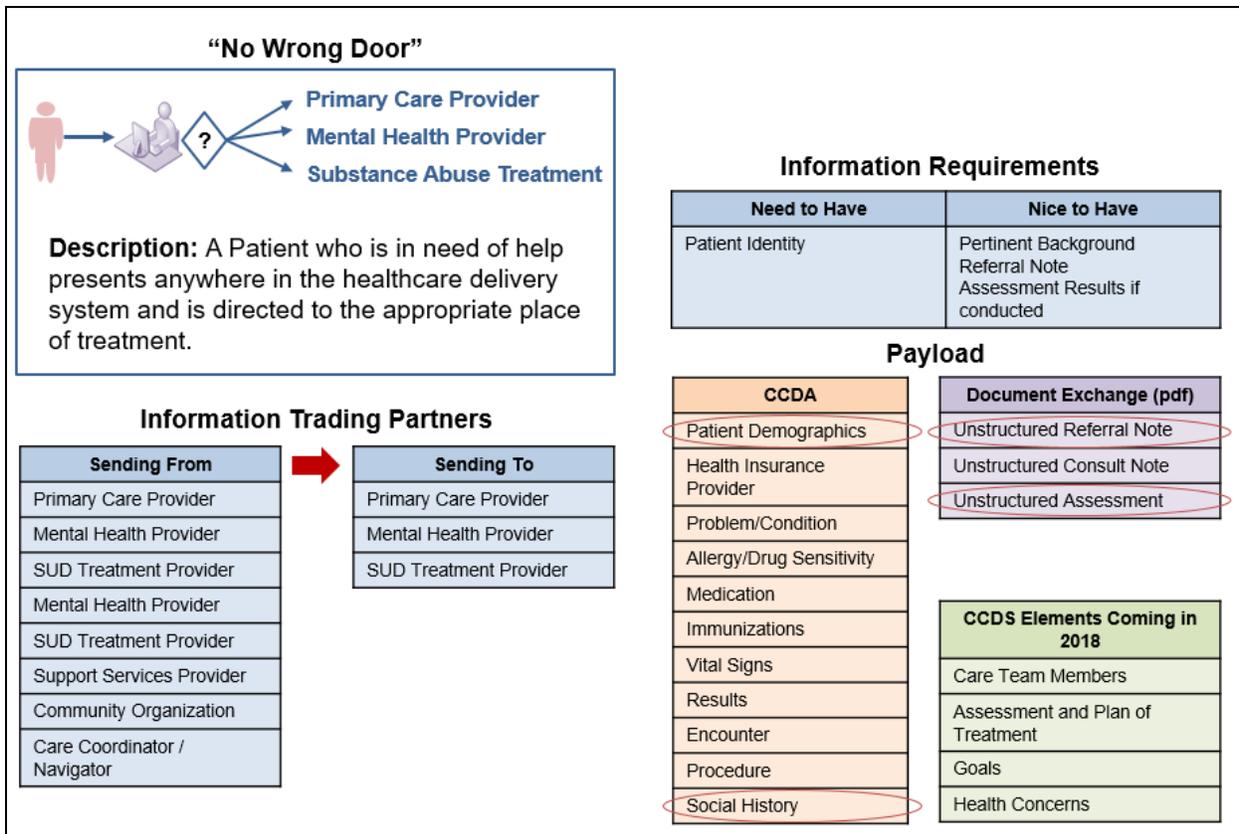
Figure 16: Referral to Supports Workflows



“No Wrong Door”

“No Wrong Door:” This is the inverse of a Referral to Supports in which a Medicaid Member is directed from a Community Supports organization to the most appropriate care setting via a closed loop referral.

Figure 17: “No Wrong Door” Workflows



The technology that supports these workflows is Direct Messaging (with or without and EHR) and is detailed in project A2.

Intake procedures that include systematically soliciting patient consent to confidentially share information among providers

Please see the section “Privacy, including limitations on information for communications with treating provider and community based organizations” above. Intake procedures to gather patient consent when required are a subcomponent of the privacy protocols.

Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of Integrated Care Practice Designation Requirements

DHHS will use the tool below to assess Integrated Healthcare Integrated Care Practice activities. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: <ul style="list-style-type: none"> • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model 	Protocols (Submit all in use)				
• B1-9c	•	<ul style="list-style-type: none"> • Use of technology to identify, at minimum: <ul style="list-style-type: none"> • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral 	<ul style="list-style-type: none"> • Table listing all providers indicating progress on each process detail 				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9d		Documented work flows with community based social support service providers including, at minimum: <ul style="list-style-type: none"> • Joint service protocols • Communication channels 	Work flows (Submit all in use)				

B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

Use the format below to identify the total number of practices/providers who have **achieved** designation as a Coordinated Care Practice or Integrated Care Practice. IDNs are expected to make continual progress toward achieving their projected number of designated Coordinated Care Practices and Integrated Care Practices.

Achieved	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	10 Included: APD, CMC, CFS, CA, MFS, NLH/NHC, Phoenix House, VRH, Headrest, Mascoma CHC	0	1	2	
Integrated Care Practice	4 Included: WCBH, D-H Leb., D-H Psychiatry, MCH	0	0	2	

Use the format below to identify the **progress** each practice made toward Coordinated Care Practice or Integrated Care Practice designation during this reporting period.

Progress Toward Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18
		10	1
	Alice Peck Day Memorial Hospital	<ul style="list-style-type: none"> Participation at IDN1 All partner events 	<ul style="list-style-type: none"> Ongoing meetings with IDN1 leadership to determine B1

			project launch and RFP
	Cheshire Medical Center/DHK	<ul style="list-style-type: none"> Submitted Project Proposal with MFS in July, 2017 B1 RFP On hold until transitions within PC are Complete 	<ul style="list-style-type: none"> Monthly project team meetings with clinical, administrative and IDN team membership Recruit to hire for clinical positions Progress underway for retrofitting the clinical space at MFS QI activities and facilitation provided by CHI
	Child and Family Services	<ul style="list-style-type: none"> Participation at IDN1 All partner events 	<ul style="list-style-type: none"> Participation at IDN1 All partner events
	Counseling Associates	<ul style="list-style-type: none"> Came onboard with IDN1 as a B1 partner Signed Subcontract with VRH for B1 project support 	<ul style="list-style-type: none"> Project team meetings with VRH B1 team Conversations for B1 support with NLH/NHC project team
	Monadnock Family Services	<ul style="list-style-type: none"> Partner proposal with CMC for B1 RFP in July, 2017 	<ul style="list-style-type: none"> Participation in monthly B1 project team meetings,
	New London Hospital/Newport Health Center	<ul style="list-style-type: none"> 2 Meetings held with IDN Admin. team to discuss next steps for B1 Involvement 	<ul style="list-style-type: none"> Ongoing work with IDN1 Admin. team to develop RFP details, Project framework and draft SOW for Subcontract
	Phoenix House	<ul style="list-style-type: none"> Participation at IDN1 All partner events 	<ul style="list-style-type: none"> Participation at IDN1 All partner events

			<ul style="list-style-type: none"> Support of CMC SUD initiatives and coordination for B1
	Valley Regional Hospital	<ul style="list-style-type: none"> Submission of B1 RFP and Project Launch 	<ul style="list-style-type: none"> Ongoing bi-weekly meetings and pre-implementation infrastructure development for Fall patient deployment
	Headrest	<ul style="list-style-type: none"> Participation at IDN1 All partner events 	<ul style="list-style-type: none"> Participation at IDN1 All partner events Support of DH-HRS SUD initiatives and participation with B1 MDCT underway
	Mascoma Community Health Center	<ul style="list-style-type: none"> Participation at IDN1 All partner events 	<ul style="list-style-type: none"> Participation at IDN1 All partner events

Progress Toward Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18
	4	0	2
	West Central Behavioral Health	<ul style="list-style-type: none"> Onboard with Project Planning Participation at all IDN1 all partner events 	<ul style="list-style-type: none"> Ongoing bi-weekly meetings and implementation of CCSA Participation in MDCT, SCP
	D-H Primary Care: Lebanon Based	<ul style="list-style-type: none"> Onboard with Project Planning Participation at all IDN1 all partner events Recruit to hire for CTC position 	<ul style="list-style-type: none"> Ongoing bi-weekly meetings and implementation of SDoH Screener Participation in MDCT, SCP

	Monadnock Community Hospital	<ul style="list-style-type: none"> • Participation at IDN1 All partner events 	<ul style="list-style-type: none"> • Ongoing work with IDN1 Admin. team to develop RFP details, Project framework and draft SOW for Subcontract
	D-H Psychiatry	<ul style="list-style-type: none"> • Onboard with Project Planning • Participation at all IDN1 all partner events 	<ul style="list-style-type: none"> • Ongoing bi-weekly meetings and implementation of CCSA • Participation in MDCT, SCP

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

C-1. IDN Community Project: Core Components, Process Milestones, Training and Evaluation Project Plans

See Appendix C-1 for Excel Workplan of C1 Activities

IDNs were required to complete an IDN Community Project Implementation Plan including design and development of clinical services infrastructure plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Provide an update to the training plan, curricula, and schedule that identifies the types and numbers of individuals by organization that will be targeted for training. Ongoing reporting for each training should include the staff name, job title, and organization for which the individual is employed.

Provide an update to the evaluation project plan that describes the IDN's approach to monitoring the performance of the project. The update will, at a minimum, include a description of performance measures that address:

- *Program impact including individuals served by the program and project adherence rates, and*
- *Fidelity to evidence-supported project elements.*

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables C-2 through C-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Updates as of 6/30/18:

The Region 1 IDN team is looking to scale the CTI model to other areas of the IDN1 catchment area in 2018 through support of a focused C1 RFP. However, given the delay in funding clarity and resolution by the State, the IDN1 Executive Committee voted again in early winter, 2018 to postpone the release of community project RFP's until summer, 2018 when funding decisions are to be finalized. This decision has greatly impacted the timeline and opportunities for CTI training with IDN1 partner agencies. Despite the lack of RFP, the IDN1 team has been addressing opportunities for expanded care transitions involvement and upcoming projects with key community support agencies in Grafton and Sullivan County. Additionally, with the CTI train the trainer session of the CACTI facilitated CTI Coordinator training taking place in August of, 2018 the IDN1 team has addressed expanded attendance for those working on the Co-pilot project. The hope being that as new projects onboard in the fall the Co-pilot team and CTI trainers can serve as a primary resource for training and clinical CTI experience. Once new projects onboard the IDN team will work with Co-pilot to facilitate and incentivize their role in training new projects. It is yet to be determined if the C1 project affiliated IDN's will renew a contract with CACTI for statewide training but if proposed, IDN1 will continue to coordinate for participation. This stands for the role of facilitated statewide CTI Community of Practice sessions as well.

Overview of the Co-Pilot Project Architecture: As reported in July, 2017 SAR

Monadnock Family Services (MFS), the Monadnock Collaborative (MC), and Cheshire Medical Center/Dartmouth Hitchcock (CMC/DH) are the three lead partners for the Co-Pilot project. This project combines implementation efforts for Enhanced Care Coordination and Care Transitions into one project that accomplishes all of the goals of the ECC and CTI work in the Monadnock sub-region of the IDN. As a collaborative team, they build upon the successful partnership between CMC/DH and MC, the local Service Link Resource Center (SL), where a coordinated care transition program for high acuity patients has been in operation for several years, adding the community behavioral health perspective and expertise well-established at MFS.

The mission of the Co Pilot program is to (a) create a person/patient-centered environment that considers and respects the desires, values, family situations, social circumstances and lifestyle of the individual, (b) to develop and coordinate a team of clinical care and community services responsive to this environment that both meets the needs and preferences of the individual and empowers their capacity for self-efficacy and (c) learn and demonstrate that new structures, practices and work flows can create a transformational delivery culture that improves satisfaction and effectiveness.

To achieve these goals, a team of community-based coordination and transition experts will be funded through this project. These individuals will effectively engage participants referred from medical services (CMC/DHK primary care teams), psychiatric inpatient facilities (New Hampshire Hospital), and involve them in person-centered care planning directly assisting them in carrying out their plan of care by accessing the community services that are needed in addressing their multiple and complex needs. Though based at MFS, team members are visible and active at the CMC/ DHK facility, communicating and consulting with the participants and their care providers in both the inpatient and outpatient service setting.

This team will seamlessly implement the (1) Critical Time Intervention (CTI) approach to provide care at staged levels of intensity to patients with serious mental illness during transitions from Cheshire Medical Center or New Hampshire Hospital to the community setting and (2) community based coordination and direct support services for recipients regarded as having complex health care needs: physical and/or mental health challenges.

In addition to the three lead partners, several community organizations will be actively involved in this project. Though not an inclusive list, to ensure a holistic view of the social and emotional needs of these patients, the following organizations will be key referral partners:

- Keene Housing: Focused on participants stable housing and supportive housing assistance
- Home Health, Hospice and Community Service: Providing in home care for participants
- Community Volunteer Transportation Company: Free transportation assistance
- Southwestern Community Services: Will be providing numerous services such as fuel assistance, vocational assistance, and emergency housing
- Monadnock Area Peer Support Agency: Providing peer support groups and respite services
- Monadnock Region System of Care for At-risk youth: Offering supplemental services to area youth

The targeted population for this project will be (1) adults living in the Monadnock Region who currently have Medicaid insurance or are Medicaid eligible, have a behavioral health diagnosis, who have experienced multiple emergency room visits or inpatient hospitalizations at Cheshire Medical Center or New Hampshire Hospital and/or also have a co-occurring long term physical health problems and/or significant barriers to successfully living in the community (i.e.: homelessness, unstable community tenure, etc.) and (2) children less than 18 years of age living with a serious emotional disturbance, particularly those with other significant family challenges regarding SDoH.

According to the statewide IDN ad hoc report, as the designated community mental health center in the Monadnock Region, MFS has received 132 discharges from NHH since July 2015, averaging about six people per month. 56.8% of those clients were admitted and discharged within the same month, indicating that many individuals needing involuntary admissions have protracted lengths of stay in that facility due to the severity of their symptoms.

In accordance with requirements for the CTI evidence-based model, the Care Transitions Coordinator will maintain a caseload of not greater than 20 patients at any time. Recognizing that not all referrals will accept services or remain within the program for the full 9 months, the 20 person caseloads will have turnover over the course of the year. During the year, it is expected that 50 patients will be served by one full time Care Transitions Coordinator (CTC) and 25 patients will be served by the half time CTC/clinical supervisor position. These positions will seek their training through the 5 Regional IDN contact with CACTI at Hunter College. The first of these direct CTC trainings will take place in fall of 2017 followed shortly by the Supervisory training. See the attached CTI Scope of Work for the Training Overview in *C1: Appendix B*.

For the enhanced care coordination component of this proposal, it is expected that 20 patients will be served by one full-time Enhanced Care Coordinator (ECC) at any one time. This figure is proposed based on the complex needs presented by these high acuity patients who will require frequent community-based interventions, telephone outreach, transportation and abundant communication with other responsible parties involved in the plan of care. The ECC role will meet all training requirements for an MFS community facing case manager and will additionally leverage across the IDN Workforce plan trainings and educational opportunities.

The partners in this project envision a community of caring that respects and supports the behavioral and social needs of the targeted population. Particularly those who are transitioning to the community from in-patient settings and those with complex physical and/or mental health needs. The purpose of the Co-Pilot project is twofold: 1.) to ensure a seamless transition for identified patients moving from NHH, CMC/DH emergency room or inpatient setting to successfully living in the Monadnock region by utilizing Critical Time Intervention and 2.) To assist high need children and adults with disabling mental health conditions to create successful lives in the community. Both aims will be accomplished by using a person-centered approach to accessing care and services, direct assistance through a wrap-around approach that assures effective implementation of the individual's plan of care, ongoing communication among parties in the medical and social service community involved in the plan of care, and a person-centered review and improvement of the plan as circumstances change.

Co-Pilot will provide CTI for the Care Transitions component of this project and incorporate the enhanced care coordination as a warm hand-off to CTI participants who do not qualify for pre-existing MFS services. This project demonstrates the collaboration with other community partners- including all organizations

within the region that serve the targeted population, to ensure increased quality of life and decreased repeated utilization of NHH, CMC/DH emergency department and inpatient stay. The proposed services include: a system for how MFS, MC, CMC/DH and NHH will communicate and coordinate to develop an effective workflow; development of referral process; implementation of the three phases of the CTI model; implementation of the enhanced care coordination model; and consistent monitoring of metrics before, during, and after CTI and enhanced care coordination services are provided. The administrative oversight for implementation of this project rests with MFS, who will provide staffing supports to ensure administrative aspects of this project are completed.

Complex case coordination adds to existing interventions available to Medicaid recipients and fills a critical role that aims to unite often disparate services. These services will augment the work of the multidisciplinary core team assisting the individual in the primary care B1 Integration work. These services will extend coordination and follow up, and actively support the adherence to the care plan in the person's home and community setting. Similarly, the Complex case coordination role will augment existing services available through MFS because they are freed from the eligibility criteria, imposed by current regulations regarding the level of severity of mental health disability that individuals must meet to obtain limited services. In this way, individuals with behavioral health conditions and significant physical health challenges can obtain a new partner in their care – a co-pilot to help them launch and land a better approach to treatment, services and health – which previously had been unavailable.

Additionally, these proposal activities are aligned with the Council for a Healthier Community (the Greater Monadnock Public Health Advisory Board) and the Monadnock Community Health Improvement Plan that identified behavioral health as one of the priority areas for the region. Services will begin no later than six months from notification of funding award in July, 2017, with efforts at goal 1 beginning within 3 three months of award. Care Transitions Coordinators, one of whom will also be the administrative lead for the project, are responsible for monitoring performance metrics, gathering data, and submitting reports to the Oversight Team. The Care Transitions and Enhanced Care Coordinators will be expected to participate in robust training, beginning with certification in the CTI model (for the Care Transitions Coordinators) and additional training topics to include but not limited to: behavioral health co-occurring chronic health conditions, medication management, health promotion programs (fitness, tobacco cessation), assessment, crisis management, HIPAA, team based collaboration, person centered planning and motivational interviewing.

Co Pilot will contain 4.1 full time equivalents. All staff will have either BA or MA level education and possess relevant experience in mental health, health care, community social services and advocacy. They will be supervised by a project manager who functions as a team leader/ administrator, coach and facilitator. He/ she will maintain program statistics and will report to the Community Support Director at MFS.

Updates for Co-Pilot January-July, 2018:

The Co-Pilot coordinated project supported by Monadnock Family Services, Monadnock Collaborative, and Cheshire Medical Center blends the project components of the C1: Care Transitions and E5: Enhanced Care Coordination projects. In the term of January-June, 2018 the project team met biweekly to work through

patient flows and project referral and process development. Additionally, the clinical team meets 2x weekly to review current cases and for team supervision.

Current staffing has 2FTE Coordinators for ECC, 2 FTE Coordinators for CTI, a 1 FTE Referral Coordinator and a clinical advisor. The Referral Coordinator serves for both CTI and ECC referrals while spending 50% of her time on site at D-HK/CMC. She accepts referrals directly from CMC staff, screens for project criteria, and makes the initial project introduction/warm hand off from hospital staff. The referral coordinator also initiates the assessment process with the PCOC tool and then synthesizes the information to bring back to the Co-Pilot coordinators for the warm case management hand off. Each CTI coordinator tracks their caseload data points and follow up protocols for CTI referrals.

Half of the Copilot team is employed by the Monadnock Family Services, the Community Mental Health Center based in Keene, NH. The primary population served by the agency is people with Severe and Persistent Mental Illness (SPMI) or Serious Mental Illness (SMI). The other half of the Copilot team is employed by the Monadnock Collaborative, the regional home for the NH ServiceLink program. ServiceLink is the federally designated Aging and Disability Resource Center and the NHCarePath full access point for citizens in NH looking for support in accessing community based long term care services and supports. The most common contacts to ServiceLink are adults with complex medical and social service needs, this may or may not include mental health issues and developmental disability issues. ServiceLink provides formal care transition support to patients discharged from CMC-DHK as part of its role as a fully functioning Aging and Disability Resource Center.

Some team restructuring took place during the January-June timeframe to accommodate for the newly hired MFS clinical director. This hire at MFS prompted the team to reassess the team configuration to allow for a shared team leadership role to be held between the new MFS clinical director and the MC program supervisor. This dyad approach to leadership has been very successful thus far in strengthening the shared clinical team dynamics and serving to diffuse some of the culture and personnel challenges that the previous team leadership model had presented. Both organizations are familiar with the challenges of integrating programs and are committed to continuous quality improvement efforts not only relating to project outcomes but also to bettering the team experience and flow.

The Co-Pilot team has been actively involved in all of the CTI trainings offered throughout the state and is a strong voice on the monthly Community of Practice sessions. These multi-IDN, facilitated CoP sessions have been incredibly valuable in sharing lessons learned and clinical tool kits.

The Co-Pilot team continues to leverage the existing Servicelink/MC care transitions specialist and the clinical models in place such as Person Centered Options Counseling along with the CTI guidance and the team determined requirements for the ECC portion of the program. Current Copilot criteria for CTI is as follows: 1. Person is making a transition from hospital, CMC-DHK or NH Hospital, back to the community. 2. Person has SMI or SPMI 3. Person is eligible for NH Medicaid. In the pre-CTI stage the team uses a person centered counseling tool that engages in patient centered options counseling and person centered goal setting. This stage assists in the relationship building and supports the CTI Phase I work.

Some primary objectives during this period of work have been:

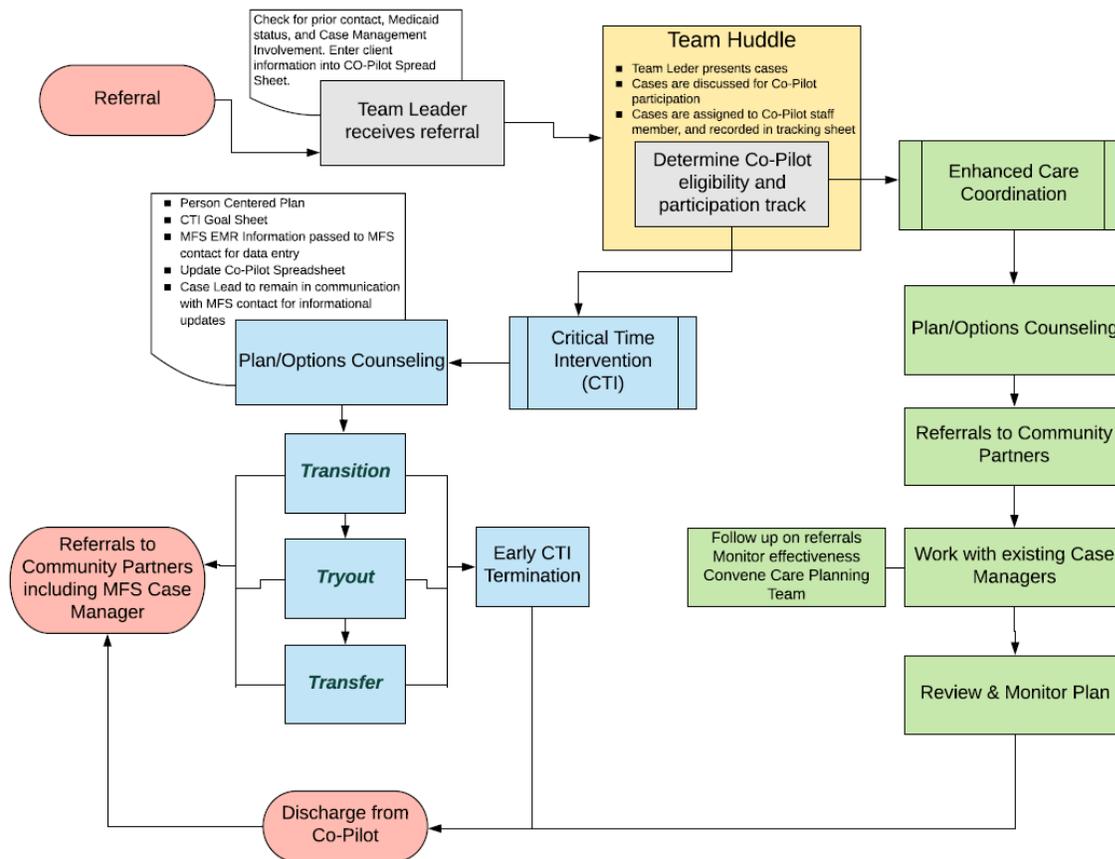
- PDSA of the Patient Referral Flow from CMC to the Co-Pilot Team
 - Built from the Care Transitions model currently co-located at Cheshire Medical Center ED

- Project Process Mapping – 3 Month Review
 - CTI Phase II, III
 - Enhanced Care Coordination Path
 - Referrals to MFS
- PDSA for Patient Screening and Data Collection
 - Revisit identified screening tools
 - Use comparative process to narrow down screening tools to 3 or fewer choices
- Data Tracking Collection Commenced

Please see below for the project materials created by the team in the January- June, 2018 semi-annual period:

High Level ECC/CTI Process Map and Program Narrative

I C1- E5 Co-Pilot High Level Project Process Map



Copilot

CTI and Enhanced Care Coordination (ECC)

Partnership of Monadnock Family Services, Monadnock Servicelink ADRC

& Cheshire Medical Center-Dartmouth Hitchcock Keene

Region 1 IDN Team, June 26, 2018

Copilot Enhanced Care Coordination (ECC)

Description

- The ECC client is on Medicaid and has a combination of complex medical needs, complex basic needs (housing, food, transportation), and mental health support needs.
- The ECC client does not fit neatly into a single type of existing case management or care coordination service but may benefit from or have multiple types of services (e.g. mental health counseling, psychiatric services, home health care services, chronic medical care coordination needs, homeless outreach services, functional support services, developmental disabilities support, ongoing targeted case management).
- ECC candidate wants support and help reaching goals and agrees to work with an ECC care coordinator and have a goal of living in least restrictive environment possible.
- ECC work is often triggered by major life event/transition, but is not specific to supporting people through a specific transition process, like transitioning from a hospital stay to home.
- An ECC client typically needs a lot of advocacy. They may have no care coordination and no services in place. Or, they may have many care coordinators in place for multiple purposes but still be confused about who to contact for what and when, and may still have difficulty living independently despite help from many agencies and systems.

Process

- ECC work is expected to be intensive, goal oriented, and reevaluated regularly.
- The Enhanced Care Coordinator works intensively for the first few months (possibly one to two times a week and multiple times by phone) to develop a trusting relationship with the individual referred and develops a person centered plan that includes all formal and informal supports that is agreed to by the individual and the all those involved (formally and informally). The plan is shared by all and updated in monthly, quarterly, or other increments as determined necessary by the person and their team.
- Major part of role is to get the person and all those involved, formal or informal, working on common goals and moving in the same direction in support with agreement from the individual.

Copilot Care Transitions (CTI)

Description

- The CTI client is on Medicaid and has a combination of complex medical needs, complex basic needs (housing, food, transportation), and mental health support needs.
- CTI supports a person from transition from hospital to home for nine months post discharge.

Process

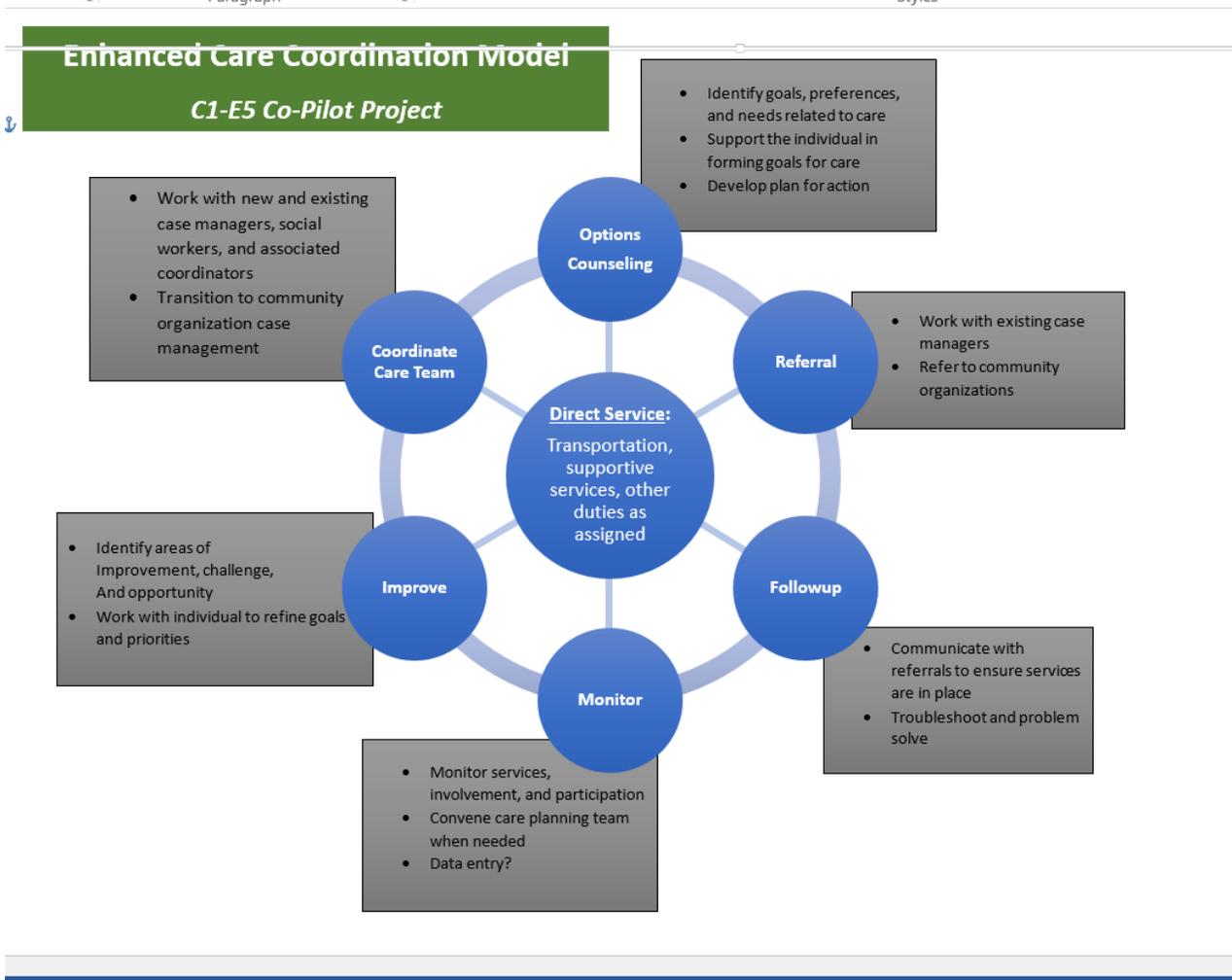
- CTI Process follows 4 distinct stages, pre-CTI, stage 1, stage 2, and stage 3. The process depends on the development of trusting relationship with a care coordinator in the pre-CTI phase, and the process is goal

oriented and helps a person achieve specific goals with gradually less support over time. If ongoing complex care coordination is identified as want or a need, the CTI care coordinator begins connecting the individual to the appropriate ongoing services for which the person is eligible (e.g. CFI case management, Mental Health Case Management, DD or ABD case management, ECC care coordination)

Re-evaluation of priority milestones:

Milestone
Review Partner Roles
Review Community Service Partner Organization partners; address gaps
Review of Case Management CTI Tool Kit
Identify Patient Assessment Protocols and Tools
Identify Patient Management Protocols
Identify Referral Process and tools
Participate in Summer 2018 Train the Trainer CTI Sessions
Develop and Formalize E5 coordinator Training
Identify participating support service organizations
Formalize relationships with support services organizations
Schedule quarterly project outcome review
Schedule quarterly report targets and deadlines
Q1 / Year Two Milestones
Year 2 funding addendum and Milestones
Conduct Year 1 Review of Program Structure
Demonstration of QI work and Implementation
Sustainability Plan

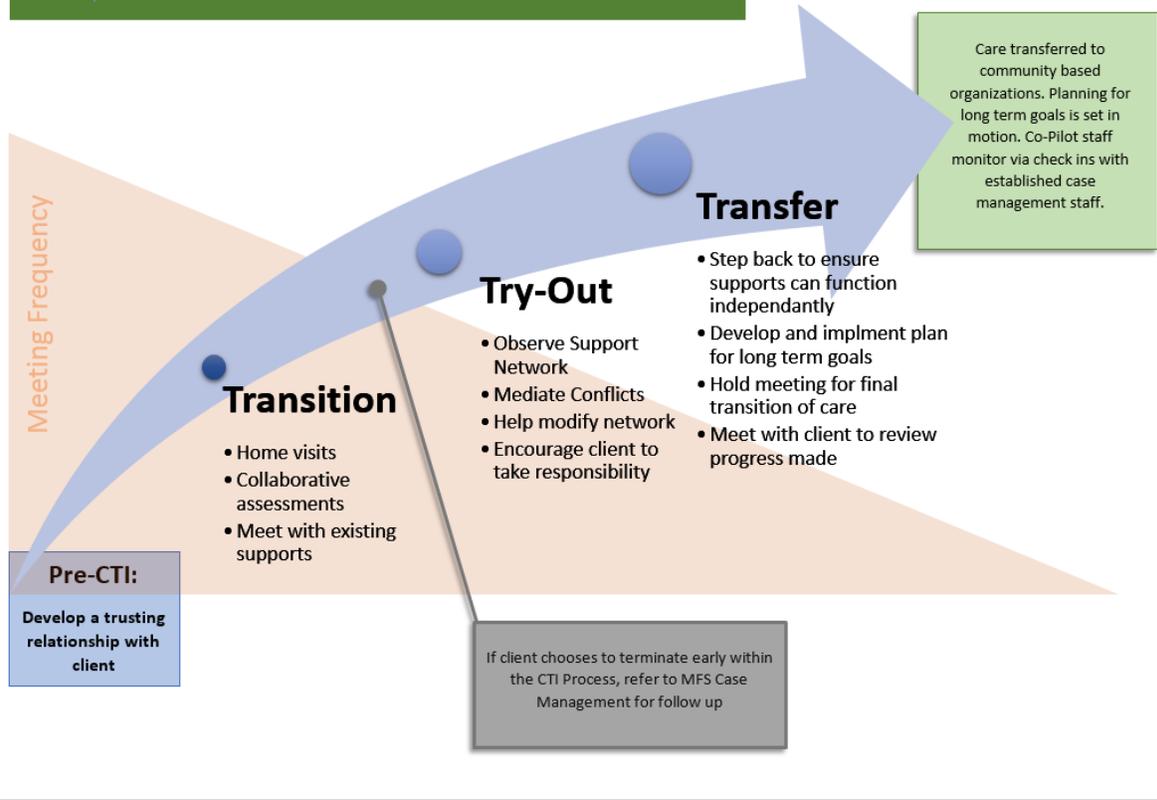
Updated ECC Process Map



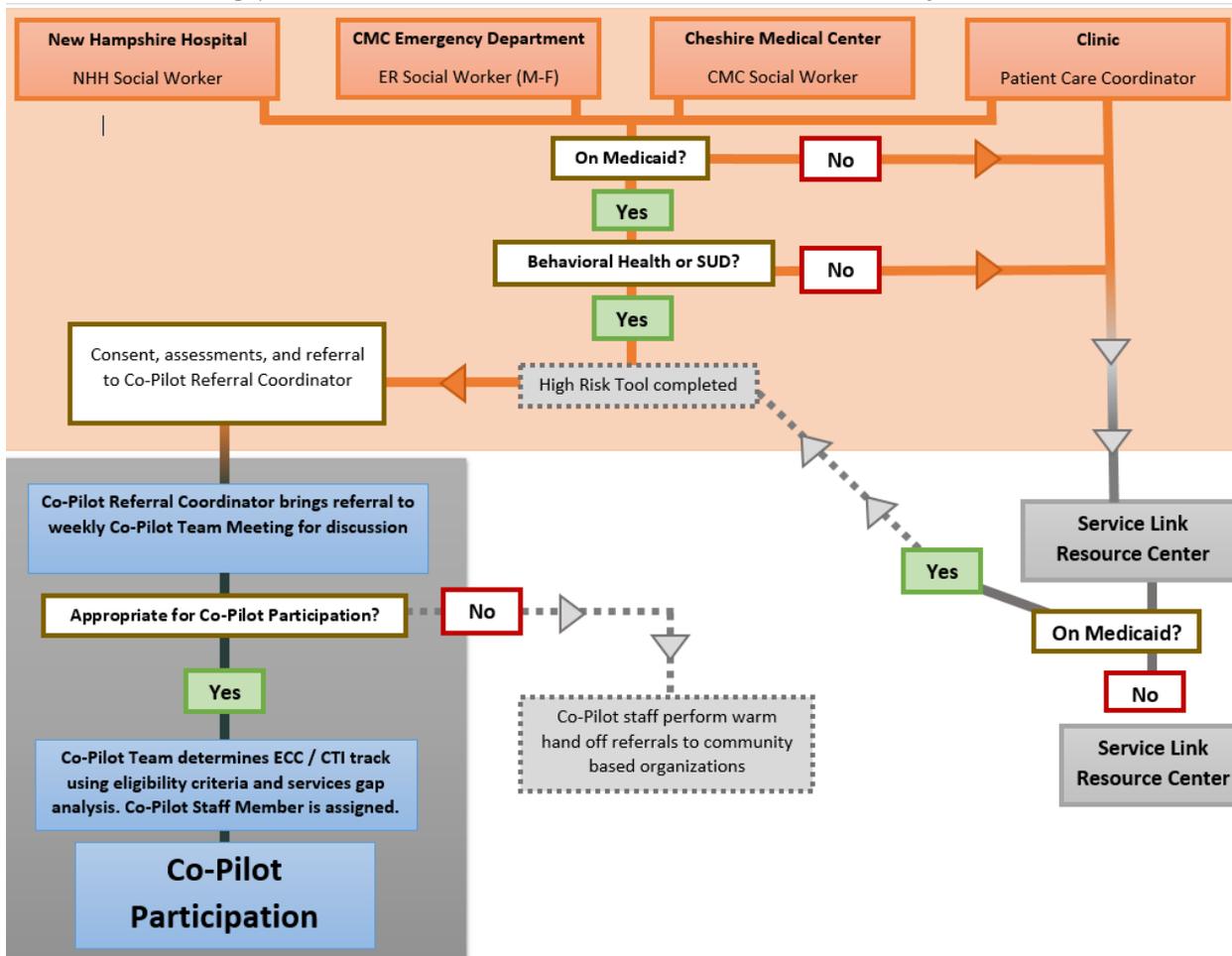
Updated CTI Process Map

Critical Time Intervention Model

C1-E5 Co-Pilot Project



Updated Referral Flow Chart



C-2. IDN Community Project: Evaluation Project Targets

From the Evaluation Project Plan, use the format below to provide a list of the progress toward targets or goals that the program has achieved. Targets required by the STCs, include but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

The Co-Pilot team began seeing patients in January, 2018 and commenced tracking of the defined performance measures.

Additional to the outcome evaluations and data reporting being collected by the team there is a quarterly evaluation table that is submitted to the IDN Program Director that includes the following:

- Milestones 1-4: Variable by team but often includes
 - Activities targeting and supporting sustainable funding efforts
 - Adherence to ongoing project work plan
- Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)

- Accountability of Time: Met or Unmet
- Participation in IDN Activities: Baseline Participation Met or Unmet

This evaluation table is used in conjunction with the on the ground support and assessment conducted at project team meetings to determine project progress by quarter and adherence to the preset terms of the project subcontract. If all areas are met or at minimum with a correction plan in place marked as In Process the quarter payment is authorized.

Please note given the early stage in project deployment and the small caseloads of the CTC team members the clinical team has been working in PDSA to determine the best methods for data capture and streamlining their systems given staffing and role transition throughout spring, 2018. The measures pledged below are being reviewed and updated as needed. Given the tri-organizational lead on the project there is a significant amount of work that goes into data coordination and capture. While the team has made marked progress in formalizing these efforts throughout the semi-annual period there are still areas where new workflows are needed to support data collection.

In regard to the missing data points below the team has indicated that given the short deployment period and rapid growth of the project over the six month term there were areas proposed for measure collection that were unobtainable. The IDN1 Program Director and the two project supervisor co-leads are meeting in summer, 2018 to firm up reporting and data collection processes for the subsequent semi-annual period. This process will review creation of new reporting and data capture fields in the Co-Pilot documentation as well as a multi-point review of the current systems and processes.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Project Defined Patient Measures				
<i>Reduce the number of poor mental health days amongst adults from 3.8 in 2015 to 2.8 in 2019 (source: County Health Rankings)</i>	Will become effective post Q1, Q2 of Project Implementation due to program launch, training	Performance measure will begin tracking in next quarter		
Indicator 1: Decrease in client self-reported poor mental health days			N/A	
Indicator 2: Increase in number of social interactions per week			N/A	
Indicator 3: Increase in participation in any groups (social, religious, self-help, public service, etc.)			N/A	
<i>Reduce overall homelessness in Cheshire county from 96 in 2016 to 86 (source: NHDHHS-County Level Information)</i>				
Indicator 1: Increase in number of people placed in housing			5 out of 14	
Indicator 2: Increase in number of people working with housing services			12 out of 14	
Indicator 3: Decrease in consecutive days without shelter			N/A	
<i>Reduce social isolation (source: GMPHN Community Survey)</i>				

Indicator 1: Increase the number of social engagements (i.e. church events, visits with neighbors/friends, attending community events)			Team reported 294 social interactions across 40 clients	
Indicator 2: Increase the number of referrals accepted for services and social resources in the community			Team reported 36 closed loop referrals to other programs or services outside of MFS	
Indicator 3: Increase the number of individuals identified as members of their support network			N/A	
STC Defined Program Measures				
<i>All performance measures identified within the evaluation plan milestones</i>	100%	100%	75%	
<i>Operationalization of Program</i>				
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	100%	100%	100%	
<i>Initiation of Data Reporting</i>				
A. Number of individuals served vs. projected			N/A	
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected			100%	
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	100%	100%	100%	

Details on the Measure Data:

Measure 2:

Across the 40 clients served by the program in January-June, 2018 there were 14 individuals that indicated a status of homelessness at point of referral. This number serves as the denominator for all three indicators addressing measure 2. The numerator for indicator 1 is reflective of individuals who entered into the program noting current state of homelessness and who indicated secure housing as of 6/30/18. For indicator 2 the numerator was drawn from the number of clients in the cohort of 14

(homeless at time of referral) who received a closed loop referral to housing services in the January-June term.

Measure 3:

Given the large scale nature of measure 3 the team is testing out feasible methods to capture the applicable data. For this submission period the indicator responses are aggregate across the full client panel for the January-June term and not pre-selected to notate the denominator figure of those clients referred to the program indicating a risk for social isolation. This will be delved into more deeply during the data and evaluation review period.

Additional to the table above please see narrative below provided by the Co-Pilot team addressing some of the data gap areas:

The Copilot project will develop a participant survey to gather self-report information related to a decrease in self-reported poor mental health days (we will change this to increase in positive mental health days in the survey), increase in the number of social interactions per week, and increase in participation in group, positive community supports, etc. The survey will also include self-reported decrease in social isolation, as outlined in the indicator measures. We believe that we can still gather retrospective data from program participants. We plan on implementing the self-reporting tool by September, 2018.

The Copilot project will also use the MFS ANSA quarterly reporting tool in our electronic health record which indeed captures much of this data – it has not been used for the Copilot program, but we are working with our EHR administrator to incorporate this tool into copilot. The projected date of roll-out is September, 2018.

Lastly, we will be working with Cheshire Medical Center so that the project can extract data from their more advanced systems on emergency room usage, improved health measures and similar reporting fields. Progress on the development of these mechanisms will be reflected in subsequent monthly, quarterly and semi-annual reports.

C-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Transition Coordinators	2 FTE	0	2 FTE	2 FTE	
Enhanced Care Coordinators	2 FTE	0	2 FTE	2 FTE	
Supervisor	1 FTE	0	1 FTE	1 FTE	

C-4. IDN Community Project: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

Updated projections for the Copilot C1/E5 project through CY2021. These budgets have been constructed to include all known components of IDN projects to date by CY but is subject to change as more details are determined in the upcoming implementation periods. Additionally, as IDN1 project subcontracts are created on implementation year and these focus on CY the balance of funds is slightly variable

Of note: the budget below is a hybrid for the combined C1/E5 project Co-Pilot. Funding for this project team is taken from both the C1: Care Transitions and E5: Enhanced Care Coordination Projects.

C1/E5: Copilot	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to December Projected	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
Total Salary/Wages							
Employee Benefits							
Supervision							
Supplies (Technology etc)							
Travel							
Recurring Expenses							
Marketing/Communications							
Staff Education and Training							
Subcontracts/Agreements(see one-time expenses)							
One Time Expenses							
Total:							
Off-setting Revenue							
Total Expenses - Revenue							

C-5. IDN Community Project: Key Organizational and Provider Participants

From Project A1: Workforce Capacity Development Implementation Plan document the Key Organizational and Provider Participants specifically related to this project in this reporting period using the format below.

Organization/Provider	Agreement Executed	Project Affiliation
	(Y/N)	
Monadnock Family Services	Y	Project Lead
Monadnock Collaborative	Y	Project Lead
Cheshire Medical Center	Y	Project Lead
Keene Housing	Y	Community Based Support Agency
Home Health, Hospice and Community Service	Y	Community Based Support Agency
Community Volunteer Transportation Company	Y	Community Based Support Agency
Southwestern Community Services	Y	Community Based Support Agency
Monadnock Area Peer Support Agency	Y	Community Based Support Agency
Monadnock Region System of Care	Y	Community Based Support Agency

C-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project. NOTE: Project C1: Care Transitions does not require the use of standardized assessment tools. If the IDN chooses to use any standardized assessment tools, please list them.

The team has experienced challenges in the CCSA (CANS/ANSA) deployment across the Co-Pilot project as similar assessment is not conducted at M.C. The team anticipates with the fall, 2018 onboarding of the B1 project at CMC/MFS standardized screening in the region will streamline the processes around some of the Co-Pilot patients. More details on this rollout are anticipated in early fall, 2018.

Standard Assessment Tool Name	Brief Description
CANS/ANSA (CMHC Mandated Screener)	Childs Needs and Strengths Assessment/ Adult Needs and Strengths Assessment
CTI Tracking Tool	CACTI Developed Patient Reporting Tool
Framed by CTI Model, Person Centered Planning	

C-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

Updates as of June 30, 2018:

The IDN1 Administrative team is working with the C1/E5 Co-Pilot team to document their project protocols for Treatment and Management into concise guidance that will be translatable for other community support agencies. A formal guidance document will be shared in early winter, 2018.

Existing Patient Flow Process: (See Patient Process Map above) The Co-Pilot team with the support of IDN project management and the QI facilitators from CHI were able to work through the end-to-end patient process for both treatment avenues of the co-pilot project for patient assessment and referral. With support from clinical staff at Cheshire Medical Center, they were able to map the opportunities pre-discharge for coordinator-to-patient linkage. Allowing for a warm hand-off for those patients eligible for CTI case management services. For high acuity patients who are not able to access the CTI coordinators, the same initial screening and referral process will link these patients to the more generalized care coordination staff supported by the project. The referral form being used by the team for the time being is being stored in Excel and captures very minimal information. The function of this tool is to serve as a first touch for the team lead and to streamline the transfer of a patient into one of the project flows. Once a patient has been linked to a project stream the coordinators will take over the input of the patient into the formal tracking systems and commence outreach activities. It is the intention of the team to use components of the shared care plan and other IDN supported IT applications to support these flows wherever possible.

Additionally, the Community of Practice sessions supported by CACTI have facilitated an open discussion across all of the IDN's implementing the C1 project as to which tools are in use and how they are being used in each Region. These conversations are ongoing and the IDN1 team anticipates that, as tools are reviewed statewide, the group streamline the assessments and protocols leveraging the best practices available. Despite variance in the populations being targeted for C1 implementation across regions, the IDN1 team feels there is sufficient synergy to make shared toolkits a positive resource for all.

Protocol Name	Brief Description	Use (Current/Under development)
Family Caregiver Assessment	Support and assistance questions, safety, & ADLs	Service Link

Person Centered (PC) Counseling check sheet	Outline of key criteria that show fidelity to a PC approach	Used by all Project Coordinators
---	---	----------------------------------

C-8. IDN Community Project: Member Roles and Responsibilities

Use the format below to identify team members and their roles and responsibilities for the project. DHHS reserves the right to audit all or a selection of the written Roles and documents used by the IDNs.

Project Team Member	Roles and Responsibilities
	CEO at MFS: Serving as the lead fiscal agency for the C1 Proposal, Additional 40 hrs. per year contribution
	CEO at Monadnock Collaborative: Serving as the housing agency for CTC Positions, Additional 40 hrs. per year contribution
	Program Director at Monadnock Collaborative: Supportive role for CT Coordinator Positions, Additional 40 hrs. per year contribution
	Director of Primary Care at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
	Nursing at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
	Director of Operations at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
	Co-Pilot Referral Coordinator
	Co-Pilot Care Team Coordinator
	Co-Pilot Care Team Coordinator
	Co-Pilot Care Team Coordinator
Clinical Supervisor at MFS	

C-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3.

All Co-pilot staff are trained in person-centered planning, motivational interviewing and case management best practices.

All applicable staff completed the 2-day CTI training held in winter, 2017. The training guided staff through the phases of CTI as well as introduced new staff to the CTI documents and tools. Examples below:

Any additional staff training will be captured in subsequent reporting periods to be held in August, 2018 IDN1 has offered slots to all sponsored and supported trainings across the IDN to the Co-Pilot staff.

CTI Phase Plan

Phase #:	Pre-CTI <input type="checkbox"/>	Phase 1 <input type="checkbox"/>	Phase 2 <input type="checkbox"/>	Phase 3 <input type="checkbox"/>
-----------------	----------------------------------	----------------------------------	----------------------------------	----------------------------------

Today's date: ____ / ____ / ____

Client's name/DOB: _____

Medicaid number: _____

Record Number: _____

Date phase starts: ____ / ____ / ____

Due date for end of phase: ____ / ____ / ____

(blank for pre-CTI)

CHECK THE GOALS FOR THIS PHASE: (Choose 1 to 3 areas)

Psychiatric treatment & medication management	<input type="checkbox"/>	Housing crisis prevention & management	<input type="checkbox"/>
Substance use treatment	<input type="checkbox"/>	Money/benefits management	<input type="checkbox"/>
Daily living skills training	<input type="checkbox"/>	Natural supports/social supports intervention	<input type="checkbox"/>

GOAL #1 _____

Reason for this goal:

Strategies:

Overall goals:

GOAL #2 _____

Reason for this goal:

Strategies:

Overall goal:

GOAL #3 _____

Reason for choosing this goal:

Strategies:

Overall goal:

Project Scoring: IDN Community Project Process Milestones

DHHS will use the tool below to assess each IDN’s Community Projects activities. Grayed areas indicate that no submission is expected for the time frame. A score of “Met” will be scored for a timely and complete submission. A score of “Not Met” will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
C-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
C-2	IDN Community Project Evaluation Project Targets	Table				
C-3	IDN Community Project Workforce Staffing	Table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
C-4	IDN Community Project Budget	Narrative and Spreadsheet				
C-5	IDN Community Project Key Organizational and Provider Participants	Table				
C-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
C-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
C-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				
C-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

D-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan

See Appendix D-1 for Excel Workplan of D3 Activities

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Provide an update to the training plan, curricula, and schedule that identify the types and numbers of individuals by organization that will be targeted for training. Ongoing reporting for each training should include the staff name, job title, and organization for which the individual is employed.

Provide an update to the evaluation project plan that describes the IDN's approach to monitoring the performance of the project. The plan will, at minimum, include a description of performance measures that address:

- *Program impact including individuals served by the program and project adherence rates, and*
- *Fidelity to evidence-supported project elements.*

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables D-2 through D-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Overview of the PATP-IOP Project Architecture: As reported in July, 2017 SAR

The PATP- IOP project pilot will build off of the existing structure of the Perinatal Addiction Treatment Program to develop and pilot an evidence-based, gender-specific, trauma-informed intensive outpatient treatment program to meet the critical treatment needs of pregnant and parenting women with substance use disorders (SUD) in the DSRIP Region 1 catchment area. The project will serve Medicaid-eligible women with substance use disorders who meet criteria for ASAM level 2.7 services, with a particular emphasis on the needs of women who are pregnant or parenting young children. The primary project objectives are as follows:

- Implement and evaluate an evidence-based, trauma-focused curriculum to meet the special needs of women qualifying for ASAM level 2.7 (Intensive Outpatient) services, including medication assisted treatment
- Address the comprehensive medical and psychiatric needs of participants through provision of co-located psychiatric and reproductive health services with linkages to primary and specialty medical care

- Develop protocols for comprehensive screening and service coordination to address social determinants of health which present particular barriers to treatment and recovery for women
- Provide on-site childcare to facilitate access to and engagement with treatment for women with young children
- Clearly define and develop the business case for a scalable, integrated intensive outpatient model of care for the target population
- Help women to consolidate their recovery as an investment in their own lives and their children's future

Currently the only gender-specific SUD treatment option in Region 1 is that provided by the Dartmouth-Hitchcock Perinatal Addiction Treatment Program (PATP) in Lebanon, a once weekly office-based outpatient program. The proposed project builds on the existing infrastructure of the current program, which includes deep knowledge of the social and health needs of this population, medication assisted treatment, weekly group therapy, peer support, integrated psychiatric and reproductive health care, and case management for pregnant and parenting women.

The PATP currently sees upwards of 40 woman during their two session clinical Wednesday. The IOP will target women from this pre-existing patient pool who need higher intensity services and from there will expand the number of individuals served. The proposed program will provide a replicable model for increasing access to intensive substance use treatment services for a population with significant vulnerability and barriers to care. Specifically, we anticipate that:

- 25-50 women of reproductive age will be provided with comprehensive, intensive addiction treatment annually that they would not be able to access otherwise
- 25-50 women with difficult to treat co-occurring disorders will be provided access to psychiatric care and will have the opportunity to stabilize their mental health disorders

25-50 women and their children will be able to access resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence.

Updates from January-June, 2018:

During the semi-annual period the PATP-IOP Expansion project team met 2x monthly in person to work on project expansion and the protocols to support programmatic infrastructure change within the project. As of January, 2018 the PATP was fully staffed and pursuing ongoing team training. The IOP began recruiting for the patient cohort in late fall, 2017 and upon securing 4 group members launched the IOP. The program objectives for the semi-annual period:

- 1) Continued expansion of referral sources for the PATP/IOP
- 2) Continued enrollment of participants in the IOP
- 3) Childcare, recovery coaching and case management inclusion in the IOP schedule
- 4) Ongoing evaluation and refinement of PATP structure, policy and procedures and curriculum, with an emphasis on smooth transitions from IOP level of care to outpatient level of care.
- 5) Focus on continuing to engage community partners in PATP program and to facilitate connections between PATP and community agencies
- 6) Continue to enrich program curriculum and refine program structure

7) Collect and interpret data regarding outcomes

Much of the work completed by the project team throughout January-June, 2018 was focused on mapping their expansion of the IOP participants, PDSA of the present processes, and refining data collection. Some completed work from January-June, 2018

Updated Patient Handbook;
Orientation Handbook Guidebook:

1. Welcome

Welcome to the **Moms in Recovery** Program. This booklet is designed to help orient you to the program. The Moms in Recovery Program is a health care program for women who are pregnant or parenting and also have a substance use disorder. At the Moms in Recovery program women can get buprenorphine treatment for opioid use disorder. They can also receive prenatal and postpartum care, well woman checkups and family planning counseling, parenting classes, case management support (such as support for finding better housing, finding transportation options, or signing up for benefits) and mental health care. Every woman in the Moms in Recovery also participates in group therapy for addiction treatment and has access to individual therapy to support her recovery.

2. Our Mission

- To provide access to addiction treatment for pregnant and parenting women who need support to manage a substance use disorder.
- To address holistically the physical, emotional, social and spiritual needs of our patients.
- To increase the number of pregnant and parenting women who remain successfully engaged in the recovery process.
- To improve collaboration between community agencies serving pregnant and parenting women with substance use disorders and strengthen the social safety net for families who are impacted by addiction.
- To assist our patients in developing the skills and supports they need in order to care for their children and build lives that are safe, fulfilling, and free from substance misuse.

3. Staff

[Redacted text block]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

3. Team Approach to Treatment

At Moms in Recovery, we work as a team to provide high quality addiction treatment to our program participants. Your treatment team includes a midwife, psychiatrists, therapists, a recovery coach, and a resource coordinator. We all work together to provide you with the best care that we can. Decisions about treatment and decisions about the program are never made by just one person. Important treatment decisions, such as making referrals to a higher level of care, are always made in collaboration with you and the entire treatment team. The Moms in Recovery treatment team meets every week to make sure everyone is updated on every patient’s progress.

4. What to Expect from Treatment

Although buprenorphine treatment (Suboxone) for opioid use disorder is one of the services you may receive here, it is only one part of the program. You will also receive prenatal and postpartum care during pregnancy, well woman check-ups and family planning counseling, parenting classes, case management support (such as support for finding better housing, finding transportation options, or signing up for benefits) and mental health care. You will participate in group therapy for addiction treatment and individual therapy to support your recovery. You will get to know other women who have been in similar situations and understand what you are going through. You will be listened to carefully and you will not be judged!

We ask you to set aside at least three hours to attend the weekly Moms in Recovery outpatient program. Please come at least half an hour before group starts so that you have time to get tested and take care of other business. The doctors and midwife see women on a first come-first served basis, so the earlier you arrive on your clinic day, the sooner you will be seen. Sometimes you may have to wait to visit with the doctor, the midwife, the resource coordinator or with your individual therapist. Thank you for your patience. We do our best to make sure you are seen as quickly as possible.

5. Your Rights

As a client of Moms in Recovery, you have several rights. The following is a list of rights you have as a client of the program.

You have the right to:

- Decide not to enter any level of treatment services that is provided at Moms in Recovery.
- Decide to terminate services at any time.
- A safe environment, free from emotional, physical, and sexual abuse.
- Be treated with respect by self, staff, and other clients.
- Be free from discrimination from self, staff, and other clients, including but not limited to racial, color, sexual orientation, national origin, disability, religious, age, gender, or economic discrimination.
- Complete and accurate information about your treatment including goals, methods, potential risks and benefits, and progress.
- Information about the professional capabilities and limitations of any professional involved in your treatment.
- Receive treatment from trained and qualified professionals.
- Be informed about the limits of confidentiality, the situations in which your counselor and/or the agency is legally bound to disclose information to outside persons or agencies, and the types of information that will be disclosed.
- Request the release of your clinical information to any agency or person that you choose.
- Be referred to appropriate community services, based on individual needs, as we are able to identify them.
- If you are asked to leave the program, to know why you are being asked to leave and what conditions you must meet in order to return.
- If you are unhappy with your care, you have the right to express this with your doctor, nurse or Dartmouth-Hitchcock Patient and Family Relations at (603-650-4429)

6. Confidentiality and Access to Treatment Records

The confidentiality of program participant records maintained by Moms in Recovery is protected by federal law and regulations. Generally, we may not say to a person outside of this hospital that a participant receives services here, or disclose any information identifying a participant as a person with a history of misusing alcohol or other drugs. The exceptions to this include (a) with written consent from you, (b) if the disclosure is permitted by court order, (c) the disclosure is made to medical personnel in a medical emergency, or (d) to report suspected child abuse and neglect or suspected elder or incapacitated adult abuse, neglect, or exploitation.

Violation of the federal law and regulations by this program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and regulations do not protect any information about a crime committed by a client either on Dartmouth Hitchcock Medical Center property, against any person who works for DHMC, or any threat to commit such a crime. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 CFR part 2 for federal regulations)

Unlike individual treatment, confidentiality of group therapy is not protected by law. Group members must be able to maintain the confidentiality of other group members in order to participate in treatment here. Violating other members' confidentiality may cause you to be discharged from this program. Program participants with concerns about confidentiality should discuss them with a staff member.

Moms in Recovery participants may access portions of their own treatment records through the Dartmouth-Hitchcock patient portal "myD-H": <https://www.mydh.org/portal/>

7. Your Responsibilities

- Attend on time to avoid disrupting group. Participants who arrive more than 10 minutes late may not be able to attend group.
- Call in advance if you need to miss an appointment; you may be required to attend a make-up group or come to the clinic to provide a UDS in order to obtain your prescription. Repeated missed appointments may result in discharge from the program.
- Make a commitment to attend recommended prenatal, postpartum, and women’s wellness visits at the program
- Do not share information about medication doses or formulations with others in group.
- Provide truthful and complete information to your treatment providers. This enables you to receive the best possible care.
- If relapse occurs, you may be referred to a higher level of care. Failure to accept this referral and/ or continued drug use may lead to discharge from the clinic.
- You are responsible for maintaining insurance or completing paperwork for financial assistance if you cannot afford the fees associated with care.
- All participants will respect the privacy of other participants in the program and will keep any information about them, including the fact that they attend this program, confidential. This means that you agree not to share anything you have heard about another person in the program or anyone you have seen while attending the program to friends, family members or acquaintances. Information about other people’s treatment, including the fact that they attend this program, on social media must never be shared. Violation of this guideline will result in a warning, and any subsequent violation will result in dismissal.
- We need to be able to contact you. You must provide program staff with a current address and current phone number as well as an alternate phone number of someone who can reach you. You are solely responsible for keeping this information current and for keeping voicemail boxes open to receive new messages.
- Smoking is prohibited near the doors of the Addiction Treatment Program.

8. Components of Treatment

- Group addiction treatment with other pregnant women and mothers
- Individual counseling for addiction and mental health needs
- Medication assisted treatment (including buprenorphine) for substance use disorders
- Prenatal, postpartum, and well-woman care offered on site
- Pediatric care offered on site
- Recovery coaching
- Help accessing resources such as housing, transportation assistance, fuel assistance, child care, etc.
- Food shelf and healthy snacks offered on site
- Diaper bank
- Donated maternity and infant items

9. Prenatal Visits/Women’s Wellness

Your physical health is an important part of your recovery! We are committed to helping you to be as healthy as possible. We offer prenatal and postpartum visits, women’s health care, immunizations; testing for sexually transmitted infections, HIV, and Hepatitis; and help getting established with a primary care provider.

10. Pediatric Care

As part of our program, you have access to on-site, recovery friendly pediatric care. This includes well child care, immunizations, sick visits, developmental checks, and Reach out and Read books. You will also have the choice to join our pediatric medical home, including 24/7 phone access and full service clinics at DHMC and Heater Road. We understand that having an infant at home can be both wonderful and stressful, so we would like to make care of your children part of your successful recovery.

[REDACTED]

[REDACTED]

[REDACTED]

12. Group Guidelines

Attendance

Consistent attendance at your assigned group is important both to your recovery and to prevention of relapse. Missing groups may jeopardize your treatment. Please call us ahead of time and let us know if you have a conflict.

Lateness Policy

You are expected to arrive at least 30 minutes before group begins in order to complete urine drug screens and take care of other business.

You are expected to be seated in the group room and be ready to start group before the scheduled start time. For example, if your group starts at 10am you are expected to arrive no later than 9:30. Anyone who is more than 10 minutes late (i.e. entering the group room later than 10:10) cannot attend group.

If you have a transportation problem that will cause you to be late, please call and let us know. If you usually attend the 10:00 am group, you may be able to attend the 12:30 group.

Participants who arrive late may be asked to attend another meeting at Rivermill as a 'make up session' and may be given a prescription that only lasts until this 'make up session.' After you have attended the make-up session you will be given the rest of your usual prescription.

Remember, punctuality is a way to be respectful of your own and other people's time boundaries.

Attitude

Members can show respect for each other by listening fully when others are speaking. Members can show respect for each other by silencing or shutting off their cell phones during groups. The group time is everyone's time. Please don't dominate the discussion. Listen 10 times as much as you speak. Practice staying out of judgement mind by working on listening skills, refraining from giving advice, learning to be comfortable with silence, using "I-statements" and reaching out with validating comments and empathy.

The Moms in Recovery Program believes it is important you are open and honest with your treatment providers and peers at all times. Openness and honesty during group can contribute positively toward your recovery goals.

Confidentiality

What is said in group stays in the group. Names of people in group stay in group. If chance brings you or another group member into contact outside of group it is best not to acknowledge each other until you've had a chance to speak about it in the next group session and have mutually agreed on whether conversation is acceptable. Never mention anything that happens in group on social media, such as Facebook or Twitter. Members with concerns about confidentiality are encouraged to speak with a clinician.

13. Playtime and Children in Groups

“Playtime” is our family support program for moms who need to bring their children to group therapy sessions. “Playtime” is a child friendly space where your child can play with specially trained, carefully selected hospital volunteers. The volunteers will hold your babies and play with your toddlers. For insurance reasons, the volunteers cannot feed your children, change diapers or help with toileting. If your child needs you, the volunteers will let you know and you will be excused from group to take care of your child.

There is room for up to four children or babies in the Playtime Space. Because space is limited, if you have another childcare option we ask you to please take advantage of it. We want every mom to have a safe space to leave her children while she attends treatment, and Playtime is a safe, comfortable place for your children. If you know you need to use the Playtime program, please sign up with our receptionist so that you can be sure there is a space available.

Moms are welcome to bring their new babies to group. Group is a place where women need a chance to focus on themselves for a few hours. If your baby is very fussy or noisy, please be respectful of other group members and take your baby out of group until she is calm.

Once your baby is older and crawling around, group is not the best place for her. Please use the Playtime program or find an appropriate caregiver for your child so you have a chance to concentrate in group.

Children who are older than four cannot come to group—it's not an appropriate place for them due to the topics that may be discussed. If you need to bring your older child with you when you attend group, and if there is space in the program, the Playtime volunteers can help supervise your child while you attend group.

Children who are younger than twelve cannot be left alone in the waiting room while you are in group. This is a liability issue for our program. If you are having trouble finding appropriate care for your older child, please talk to our resource specialist who may be able to help.

14. The Parent Education Program

We offer a parent education group about four times a month using a curriculum called Circle of Security. Women who struggle with substance use disorders, and women who grew up in families where addiction was a problem, often have guilt and anxiety that interferes with their ability to relax and enjoy time with their children. These feelings can interfere with the ability to set healthy limits with your children and manage their intense feelings. Circle of Security is a program that helps parents develop a secure, healthy

attachment with their children. The program lasts for eight weeks. If you have completed the IOP or nine months of treatment with the Moms in Recovery program and you are in a stable place in your recovery, you are welcome to join the Parenting Group. The Parenting Group counts as your weekly group therapy. After you have completed the Parenting Group you can request to join the maintenance group and attend group less frequently.

15. Pathway through Treatment

Most women enter our program while they are pregnant. If you are pregnant you will attend the Pregnancy Group every week until after your baby is born. Once your baby is between six and twelve weeks old, you will join the Postpartum Group instead.

Some women come into treatment after their babies are born. If your baby has already been born, you will begin treatment in the Postpartum Group.

Some women enter treatment through the Intensive Outpatient Program (the IOP). If you are pregnant when you begin the IOP, you may continue with the Pregnancy Group after you complete the IOP. If you are not pregnant, you will join the Postpartum Group after you complete the IOP.

Every woman coming into the program can expect to attend group on a weekly basis for between 40 and 60 weeks—how long you continue weekly groups depends on your progress in treatment, how stable you are in your recovery and what kind of support works for you. After you have been in the program for at least nine months, and once you have completed the Parenting Education Program, you can request to go onto a maintenance schedule. Women who have switched to a maintenance schedule attend group either every two weeks or every four weeks.

16. The Intensive Outpatient Program

The Moms in Recovery Intensive Outpatient Program (IOP) will begin in February 2018. Any pregnant or parenting woman who meets criteria for an IOP level of care can join the IOP. Women in the Moms in Recovery program who are struggling with relapse may be asked to complete the IOP in order to maintain their health. The IOP schedule is:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

17. Urine Drug Testing

- All program participants will provide a point-of-care urine sample for a toxicology screen for substances of abuse and buprenorphine at each visit, regardless of whether a prescription is needed that day. This urine sample will sometimes be observed by a staff member.
- Urine samples will be periodically sent out for confirmatory testing, which may include testing for alcohol metabolites, bath salts, or other illicit substances.
- It is a felony in NH to obtain a prescription using deceit, so any adulteration of urine specimens will be considered to be the commission of a crime on premises. As such, confidentiality rules such as 42 CFR Part 2 and HIPAA do not apply. We reserve the right to immediately discharge patients and notify law enforcement if urine specimens are adulterated.

- Refusing to provide a urine drug screen is considered the equivalent of a positive drug screen
- The consumption of poppy seeds in any form during your participation in our program is prohibited, as poppy seeds can confuse our urine tests and are indistinguishable from opiate use.

18. Coping with Relapse

We recognize that relapse is part of the disease of addiction. Not everyone in recovery from addiction will relapse, but that potential is always there. Part of the education you receive in group therapy will be about how to prevent relapse and what to do if you do have a relapse.

If you test positive for a substance you should not be using, such as opiates, alcohol or cocaine, members of your treatment team will discuss this with you individually and develop a plan to make sure you have the support you need to stop using. This may include increasing the frequency of your individual therapy sessions, going to twelve step groups and making lifestyle changes. If you test positive for an illicit substance two weeks in a row, we will refer you to a higher level of care. This could be the Intensive Outpatient Program (IOP) or it could be a residential treatment program.

Marijuana

Many program participants are daily marijuana users when they enter our program. Some started using marijuana when they were very young. If you are a regular marijuana user, you may feel ready to stop using opiates or other “hard drugs” like cocaine, but feel that marijuana is ok for you. Some women feel that marijuana helps with nausea, or pain, or anxiety.

Moms in Recovery is an abstinence-based program. That means that we ask participants to remain abstinent from all mood-altering substances, including marijuana. There is growing scientific evidence that marijuana is not safe to use while you are pregnant or breastfeeding. We also feel that marijuana is not safe to use while you are supervising children. Finally, we believe that marijuana use is not safe for anyone who has a substance use disorder because it increases vulnerability to relapse. It is also the belief of your treatment team that marijuana use interferes with healing for people who have Post Traumatic Stress Disorder, anxiety, or depression.

We recognize that stopping marijuana use is a difficult process for some people who have been using it for a long time. While you are pregnant, we will provide you with information about marijuana use and how it can impact your baby and your recovery.

Women who are testing positive for THC are not eligible to be on a “maintenance schedule”. If you test positive for THC you will be asked to attend weekly group therapy sessions until your drug screen is negative for THC again.

19. Child Protection Communication

Families have both strengths and challenges and can grow and change with support and resources. Moms in Recovery staff are committed to helping you ensure the safety of yourself and family. We know you are eager to provide a safe home for your children and that the health and safety of your child is a priority. Untreated substance use disorders can affect prenatal development, parenting, and early childhood and adolescent development, but treatment can prevent these outcomes. If we have concerns about the safety of your children we will discuss these concerns directly with you. We recognize that you know your situation and family the best. Please remember that we are mandated by law to report suspected child abuse and neglect to child protection agencies. If we need to make such a report, we will communicate

this directly to you whenever possible, and encourage you to partner with us in making the report. Child protection agencies work with families to help parents get the services and supports they need to keep their children at home safely and will place children in temporary out of home care only when necessary. Please speak with a clinician if you have concerns or questions about child protection involvement or communication.

20. Medication-assisted Treatment

- Buprenorphine is prescribed as part of an overall effort to help people become abstinent from opioids. The goal of treatment is total abstinence from all drugs of abuse, including alcohol and marijuana.
- Mixing buprenorphine or methadone with sedatives such as alcohol, benzodiazepines, or barbiturates is very dangerous due to the risk of respiratory suppression (stopping breathing). Participants who are taking benzodiazepines on entry to treatment will be assisted in tapering off these medications. Following completion of a taper, participants admitting to the use of, or testing positive for, benzodiazepines, barbiturates, or alcohol will receive one written warning and sign a contingency contract. Participants admitting the use of, or testing positive for, these substances a second time may be discharged from the clinic with a one to two-week taper of buprenorphine. Participants refusing to sign the contingency contract will be given a one to two-week taper of buprenorphine and will be discharged from the clinic
- The total dose of buprenorphine will not exceed 16 mg for any patient, other than occasionally in the third trimester of pregnancy.
- Suboxone (buprenorphine/naloxone) is safe and effective for both pregnant and non-pregnant women. Anyone who joins the program taking Subutex (buprenorphine monotherapy) during pregnancy will immediately be transitioned to Suboxone (buprenorphine/naloxone) postpartum.
- We ask all program participants to pick a “home pharmacy” and sign a release of information for that pharmacy.
- Lost or stolen prescriptions will not be replaced. Program participants who allow their medication to be stolen or lose their medication more than once will be discharged from the clinic.
- We periodically call program participants to come in for unscheduled pill/strip counts and urine drug screens. When this occurs, you have 24 hours to present to the clinic or you may be discharged from the clinic. It is your responsibility to have a working phone number, and not receiving the message will not prevent discharge.
- Women who are on methadone maintenance treatment are welcome to attend group and participate in all aspects of the program. Because Moms in Recovery does not prescribe methadone, women choosing treatment with methadone need to obtain medication from another program, usually Habit Opco in West Lebanon).
- Women choosing treatment with buprenorphine (Suboxone) for medication assisted therapy must receive their prescriptions through our program in order to participate. Patients who are prescribed buprenorphine by other providers are not eligible to receive Moms in Recovery services.

21. Diversion

It is against the law to provide a controlled substance to another person to whom it is not prescribed. Program participants who divert their buprenorphine by selling or sharing it with others will be immediately discharged from the clinic with a one to two week taper of buprenorphine. The diversion does not have to be established “beyond a reasonable doubt”. Buying, selling, or sharing illicit substances with other group members will also lead to discharge.

22. Making Changes in Your Life

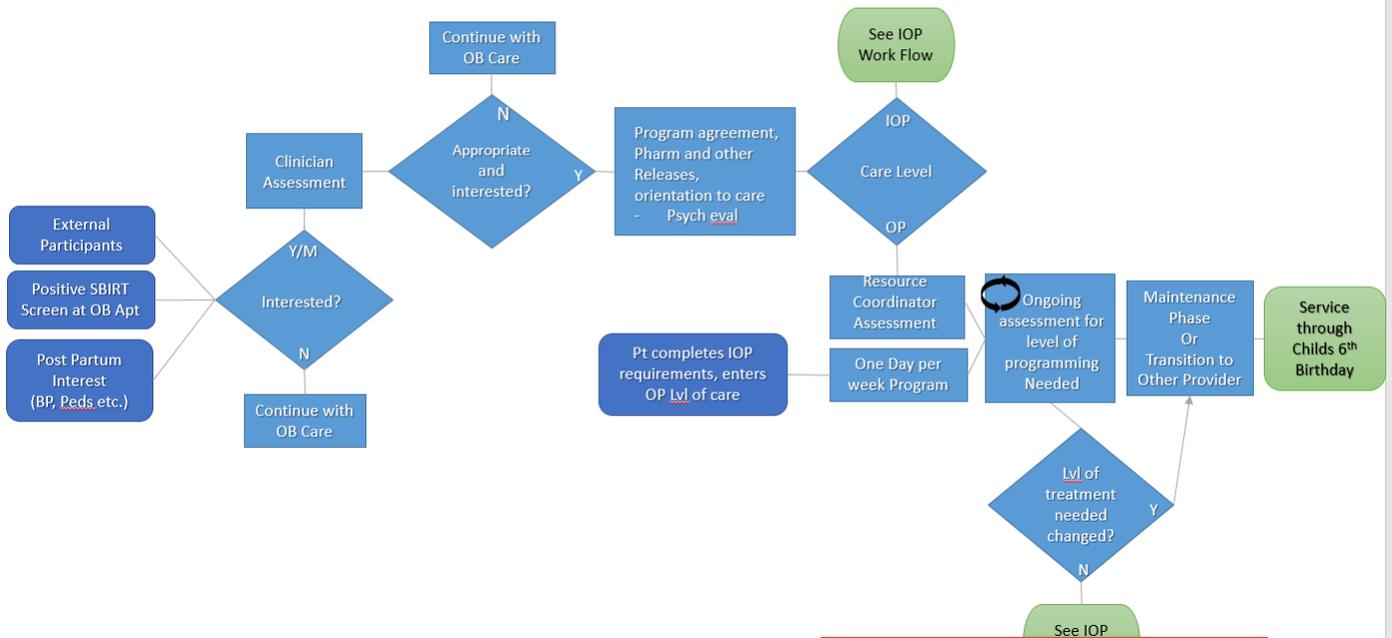
Life changes are difficult for anyone, but especially for those living with the disease of addiction. Good, bad, or indifferent, making a change can feel overwhelming and distressing, particularly for those of us suffering from this disease. Becoming a new mother and choosing recovery at the same time might feel like it's too big a task for anyone to accomplish. The team of experienced, understanding and non-judgmental staff at the Moms in Recovery Program are here to help you move forward in becoming both a successful parent and a person who is in recovery from addiction. There is no doubt that both come with their own sets of struggles, joys, and imperfections. But here you can gain confidence, knowledge, support, and the reassurance that you are never alone in your journey. Everyone deserves a quality of life worth living and everyone deserves a chance to be healthy

Organizations Receiving Information and Outreach:

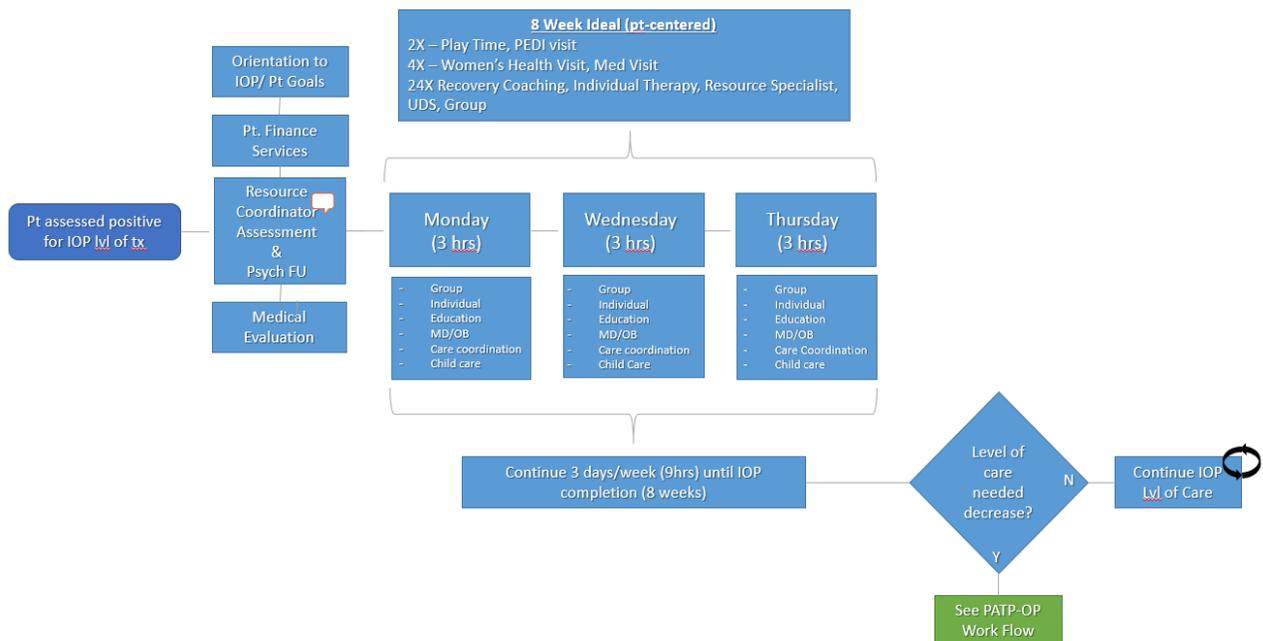
Road to a Better Life
Groups
Habit Opco
West Central Behavioral Health
Little Rivers Health Clinic
Bradford Psychiatric Associates
Road to a Better Life
Phoenix House
Wise
TRAILS Program
TLC Family Resource Center
Turning Points Network
Upper Valley Haven
Family Place Parent Child Center
Twin Pines Housing Trust
Headrest
Women's Health Resource Center
Listen Thrift Store
Child Support District Office
Upper Valley Public Health Council

Updated Process Maps:

DHMC: PATP-OP Future State Program Flow



DHMC: PATP-IOP Future State Program Flow



D-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list of all of the progress toward targets or goals that the program has achieved. Targets required by the STCs include, but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

The PATP-IOP project team during January to June began collecting on the seven defined core performance measures which were selected as the foundation for program evaluation. Those measures and their operational definitions can be found below. Given the early stage of the IOP operation there is an ongoing PDSA for project outcomes measurement and measure reframing. Any formal changes or additions will be captured in subsequent reporting.

In addition to the outcome evaluations and data being collected by the team, there is a quarterly evaluation table that is submitted to the IDN Program Director. It includes the following:

- Milestones 1-4: Variable by team but often includes
 - Activities targeting and supporting sustainable funding efforts
 - Adherence to ongoing project workplan
- Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)
- Accountability of Time: Met or Unmet
- Participation in IDN Activities: Baseline Participation Met or Unmet

This evaluation table is used in conjunction with the on-the-ground support and assessment conducted at biweekly project team meetings to determine project progress by quarter and adherence to the preset terms of the project subcontract. If all areas are met, or, at minimum is marked as “In Process” with a correction plan in place, the quarter payment is authorized.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of Medicaid women successfully completing the IOP program		Program Not Started	N/A	
Number of women engaged in continuing care one month following completion of IOP			N/A	
Number of negative UDS at end of program			N/A	
Number of women receiving reproductive health services visit			89%	
Number of pregnant women who attend recommended prenatal visits during program			100%	
Number of women with established PC relationship			78%	
All program participants are screened for SDoH			78%	
STC Defined Program Measures				
<i>All performance measures identified within the evaluation plan milestones</i>	100%	100%	100%	
<i>Operationalization of Program</i>				
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	100%	100%	100%	
<i>Initiation of Data Reporting</i>				
A. Number of individuals served vs. projected	100%	100%	75%	

B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected			100%	
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements			100%	

Details of the Reporting Measures: January- June, 2018

1) Number of women successfully completing the IOP program	0	
o Completion is: 22 sessions completed within an 18 week period		
Number of women currently enrolled	5	
Number of women discontinuing program prior to completion*	4	*Each IOP treatment episode is reported separately
If discontinuing program, disposition:		
Office based treatment	1	
Residential treatment recommended, treatment status unknown	1	
Residential treatment confirmed	1	
No known treatment on discontinuation of program	1	
2) Number of women engaged in continuing care one month following completion of IOP	N/A	(See above)
o Continuing Care is:		
§ Return to OP level of care		
§ Transfer to other OP or IOP		
§ Discharge to higher level of care		
3) Number of women with negative UDS at end of program*	N/A	*No patients have completed program yet
o Less than 50% testing positive for THC by the end of an IOP		
o Less than 25% testing positive for any non-prescribed substance other than THC		
4) Number of women receiving reproductive health services visit		
o Health Services visit includes:		
Hepatitis B screening*	67%	* ordered= 100%
Hepatitis C screening*	67%	* ordered= 100%
HIV screening*	67%	* ordered= 100%
Chlamydia and gonorrhea screening	89%	
§ PAP history reviewed, updated if indicated	89%	
5) Number of pregnant women who attend recommended prenatal visits during program*	100%	*One pregnant patient
6) Number of women with established relationship with a primary care	78%	
o At least one visit with a PCP in the past 12 months	67%	

7) All program participants are screened for Social Determinants of Health*

78% *7/9 participants screened to date.

Proportions represent patients screening positive.

o SDoH assessment includes :

§ Housing	29%
§ Financial Strain	86%
§ Education	0%
§ Social Isolation	29%
§ Transportation	86%
§ Employment	43%
§ Legal Issues	43%
§ Interpersonal Safety	71%

o Data pull will include # of positive screens, % month to month, domain area with highest + screens quarterly, annually

D-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
<i>Masters Level clinician (BH)</i>	1.5 FTE	Recruit to Hire	1.5FTE	1.5FTE	
<i>Psychiatry (MD, ARNP)</i>	.3 FTE	Recruit to Hire	.3FTE	.3FTE	
<i>OB/GYN(ARNP, CNM)</i>	.1 FTE	Recruit to Hire	.1FTE	.1FTE	
<i>Pediatrician (MD, ARNP)</i>	.1 FTE	Recruit to Hire	.1FTE	.1FTE	
<i>Certified Medical Assistant</i>	.5 FTE	Recruit to Hire	.5FTE	.5FTE	
<i>Social Work Case Manager</i>	.5 FTE	Recruit to Hire	.5FTE	.5FTE	
<i>Recovery Coach</i>	.5 FTE	Recruit to Hire	.75FTE	.75FTE	
<i>Childcare Providers</i>	.75 FTE	Recruit to Hire	.5FTE	.5FTE	
<i>Administrative Support Staff</i>	.5 FTE	Recruit to Hire	.5FTE	.5FTE	

D-4. IDN Community Project: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project. After 6/30/17, updates must include financial reporting.

Updated projections for the PATP/IOP D3 project through CY2021. These budgets have been constructed to include all known components of IDN projects to date by CY but is subject to change as more details are determined in the upcoming implementation periods. Additionally, as IDN1 project subcontracts are created on implementation year and these focus on CY the balance of funds is slightly variable.

D3: PATP/IOP	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to December Projected	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected
Total Salary/Wages							
Employee Benefits							
Supervision							
Supplies							
Travel							
Purchased Service							
Staff Education and Training							
Other: Cost							
Total							
Projected Revenue Offset							
Total IDN Funds							

Updated Expenditures and Budgeted Line Items as of 6/30/18

<i>Overview Financing to Date</i>			
	Budgeted Amount	Actuals Spent in Quarter 4/1/18-6/30/18	Actuals Spent to Date 6/30/18
<i>Staffing</i>			
<i>Fringe Benefits</i>			
<i>Purchased Services (Recovery Coach Salary)</i>			
<i>Supplies</i>			

D-5. IDN Community Project: Key Organizational and Provider Participants

From Project A1: Workforce Capacity Development Implementation Plan, document the Key Organizational and Provider Participants specifically related to this project in this reporting period using the format below.

Organization/Provider	Agreement Executed
	(Y/N)
Dr. William Torrey on behalf of D-H Psychiatry	Y
Dr. Keith Loud	Y
Dr. Leslie DeMars	Y

D-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project.

No change in the January-June, 2018 semi-annual period to the assessments used by the clinical team for the IOP cohort. Potential expansion of tools used will be included in subsequent reporting periods.

Standard Assessment Tool Name	Brief Description
Comprehensive Intake Assessment	This assessment will be paired with use of the Addiction Severity Index (ASI) as well as face to face evaluation with an addiction clinician. The initial assessment will be used as a starting point for clients to access the services available through the PATP-IOP listed below.
	Psychiatric evaluation Complete medical and reproductive health history Collaborative development of an individualized treatment plan by the participant and her care team, addressing all ASAM domains, medical, and psychiatric needs 8-week intensive outpatient program with 3 group sessions weekly (9 hours) including psycho-education and evidence-based group therapy utilizing trauma-informed, gender-relevant approaches Individual counseling Medication assisted treatment when indicated Smoking cessation counseling and treatment Peer support/recovery coaching Case management Life skills programming (including skill development regarding parenting skills, healthy relationships, nutrition and self-care) On-site childcare when mothers are in individual or group therapy Urine drug screens and breathalyzer testing
The PPATP-IOP will incorporate Motivational Interviewing, Cognitive Behavioral Therapy and Dialectical Behavioral Therapy as foundational approaches to addiction treatment, all of which are evidence-based practices. In 2017 the current PATP will begin to incorporate the Circle of Security Parenting Program.	

D-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

Updates as of June 30, 2018:

The IDN1 Administrative team is working with the PATP-IOP project team to document their existing protocols for Assessment and Referrals. A formal guidance document will be shared in fall, 2018.

The PATP-IOP project team worked diligently throughout fall, winter 2017/2018 in preparation for the expansion to 3 weekly clinical days to support the PATP IOP. Much of this work centered on process mapping and workflows for new patient referral, daily treatment flow, and new process development. With the support of the QI facilitator from CHI, the team was able to use process improvement tools to streamline and formalize this work. Two formal protocols born out of this work were the IOP treatment contract and the formal IOP curriculum. Both tools are based on pre-existing PATP OP frameworks, which, in turn, are derived from evidence-based best practices used at similar programs throughout the country. They blend the strongest components of each project structure to suit the particular needs of this specific population and the culture of the PATP program.

The PATP-IOP went live with a patient pilot group in the IOP in early spring, 2018. This small cohort launch has allowed the clinical team to work through ongoing process improvement to the development of patient pathways and protocols. At this point in project development the team has a robust collection of IOP materials, workflows and protocols.

Protocol Name	Brief Description	Use (Current/Under development)
Treatment Contract	Contract specific to the IOP program. Derived from the OP PATP contract framework	In Use
IOP Curriculum	8 week clinical curriculum that guides the PATP-IOP	In Use

D-8. IDN Community Project: Member Roles and Responsibilities

Using the format below, identify team members and their roles and responsibilities for the project. DHHS reserves the right to audit all or a selection of the written Roles and documents used by the IDNs.

No change since full staffing as of July-December, 2017 reporting:

Project Team Member	Roles and Responsibilities
1.5 FTE Masters Level Clinician	(3 half-time positions in total) (LCSW, LCMHC, LMFT, MLADC), one of whom will serve as Behavioral Health Coordinator, taking a lead role in coordinating the program and supervising case manager, childcare staff,

and recovery coach. Provide group and individual therapy, conduct intake process and level of care assessments, develop individualized treatment plan for each client. Provide phone coaching and outreach to strengthen engagement, decrease drop-out rate, and care coordination with outside agencies such as Child Protective Services, Probation and Parole

0.3 FTE Psychiatry	(MD, ARNP) with buprenorphine waiver, who will serve as medical director of program and supervise masters-level clinicians. Provide psychiatric evaluation and psychiatric medication management where appropriate. Provide medication assisted treatment with buprenorphine and/or other medications to address substance use disorders (e.g. naltrexone)
0.1 FTE OB/Gyn	(ARNP, CNM) Provide women's health services including prenatal, postpartum, and well woman care. Coordinate health education with regard to women's health and pregnancy related topics. Assist women with establishing care with a Primary Care Physician.
0.1 FTE Pediatrician	(MD, ARNP) Provide well child care and pediatric services to children of enrolled women. Consult to other providers regarding child health. Coordinate health education on pediatric topics.
0.5 FTE Certified Medical Assistant	Assist in check in process, conduct urine drug screens including observed UDS when appropriate, conduct queries in VT and NH Prescription Monitoring Program at intake and periodically. Assist with prior authorization process. Track and coordinate calling patients in for random urine drug screens and pill/strip counts. Occasionally assist in medical procedures with women's health or pediatric provider (e.g. pelvic exams)
0.5 FTE Social Work Case Manager	(MSW preferred, BSW/BA considered) Conduct psychosocial assessment for each client and assist in connecting with community resources. Coordinate with community providers both for donations and for visits to the program to speak with clients. Track usage of community services. Coordinate health education program; engage community speakers and adjunctive services (i.e. diaper bank, food shelf, dental care, etc.)
0.5 FTE Recovery Coach	Provide peer support services, education, overdose prevention, connection to community recovery resources for enrolled clients. Attend group sessions as scheduled.
0.75 FTE Childcare Providers	Supervise children while parents are in treatment, coordinate volunteer child care aide program, maintain play space, manage registration process for parents using the family support services
0.5 FTE Administrative Support Staff	Schedule appointments, update insurance and contact information, check patients in on arrival, answer phones and convey messages, track completion of intake paperwork and appropriate releases of

information. Assist with completion of prior authorizations and prescription data monitoring program queries.

D-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3

Given that the PATP-IOP team has been operational since fall of 2017 and fully staffed as of December, 2017 the team has completed all of the preliminarily identified trainings needed for IOP launch- with additional trainings being included as needed or identified by staff role. The culture of the PATP is that ongoing training is a standard, and, as learning opportunities come up and interested staff are available the training is added. Additionally, the PATP-IOP staff are included on all IDN sponsored training opportunities and are active participants in the IDN network.

The current IOP curriculum was developed and honed over a number of years as the clinical team sought to expand the pre-existing OP program. In the early months of project planning they vetted curriculum content from existing programs across the country. The curriculum review continues in a slow cycle PDSA following the intended point of completion of each IOP cohort. The current framework is outlined below;

Moms in Recovery IOP Curriculum

Monday

Topic: Relationships and Self-Esteem

Materials:

A Woman's Addiction Workbook by Lisa Najavits "Healing through Relationships"

DBT Skills Training Handouts by Marsha Linehan "Interpersonal Effectiveness Skills"

Connections Curriculum by Brene Brown

Wednesday

Topic: CBT and Relapse Prevention; Health Education

Materials:

Seeking Safety Curriculum by Lisa Najavits

Relapse Prevention materials by Melissa Baughman/DHMC IOP

(The Health Education Program introduces speakers on various topics related to pregnancy, parenting and women's health)

Thursday

Topic: Mindfulness and Emotion Regulation

Materials:

DBT Skills Training Handouts by Marsha Linehan, "Emotion regulation skills, mindfulness skills and distress tolerance skills"

Experiential learning

Project Scoring: IDN Community Project Process Milestones

DHHS will use the tool below to assess each IDN's Community Projects activities. Grayed areas indicate that no submission is expected for the time frame. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
D-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
D-2	IDN Community Project Evaluation Project Targets	Table				
D-3	IDN Community Project Workforce Staffing	Table				
D-4	IDN Community Project Budget	Narrative and Spreadsheet				
D-5	IDN Community Project Key Organizational and Provider Participants	Table				
D-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
D-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
D-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				
D-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

E-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan

See Appendix E-1 for Excel Workplan of E5 Activities

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

Using Microsoft Project or similar platform update your project timeline to reflect progress made during this reporting period.

Provide an update to the training plan, curricula, and schedule that identify the types and numbers of individuals by organization that will be targeted for training. Ongoing reporting for each training should include the staff name, job title, and organization for which the individual is employed.

Provide an update to the evaluation project plan that describes the IDN's approach to monitoring the performance of the project. The plan will, at minimum, include a description of performance measures that address:

- *Program impact including individuals served by the program and project adherence rates, and*
- *Fidelity to evidence-supported project elements.*

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables E-2 through E-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Overview of the E5 Project Team Restructuring: As reported in June-December, 2017 SAR

The coordinated entry project through the term of July-January commenced bi-weekly meetings in September, 2017 with a team of 5 core project team members. Supporting representation from IDN1, Quality Improvement facilitation, VRH clinical staff, and the Sullivan County Continuum of Care. This core team targeted a 6 month work plan based on the implementation timeline and steps proposed in the July, 2017 submission of the SAR.

Core Process Milestones:

- Development of Screening and Barrier Assessment Tools
 - Project team members supported tool review and conducted outreach to project partners for additional assessment
- Release of Information
 - Review of the VT Coordinated Entry forms
 - Meetings with IDN1 HIT/Data support
- All Partner Meeting and Complex Case Management – Leveraging an existing Sullivan County partner development meeting the coordinated entry team

Given significant capacity limitations within the internal team designated to steward the coordinated entry project, there were significant delays to the project development. The core team at VRH worked to move forward with project process milestones their limited bandwidth allowed. The team successfully met bi-weekly throughout the fall and early winter, 2017. In mid-December, 2017 the project team, senior leadership at VRH, and members of the B1 team met for a 90 minute session to brainstorm next steps for the project. This meeting yielded some positive reframing but given continued ambiguities in regard to project implementation, the project team suspended meetings to allow for IDN restructuring. The IDN and QI support have been meeting through late December to review the project process thus far and think about potential areas for change:

Areas of Project Success:

- Project was seated within a Critical Access Hospital with indicated assessments of need from the community
- Project was based off a model that is used to address social determinants of health (SDoH), called Coordinated Entry based in VT.
- Aimed to create a “No Wrong Door” policy for those with mental health (MH) and substance used disorder (SUD)
- IDN supported weekly internal team meetings with the VRH Coordinated Referral team
- Discovered champions in the MH/SUD community
- Utilized community partners to help develop the materials for the project
- Framework developed for the Complex Case Management partner meeting
- Review of referral and assessment templates and forms for project use
- Informed the community on project updates and engaged relevant partners in decision making, especially surround the ROI
- Successful collaboration with VRH’s B1 project

Areas of Challenge:

- Communication between Region-1 IDN and internal VRH E5 Team
 - Establishing workflow with to do items and follow up protocol
- E5 Project that was proposed had already been through a three year vetting process in the State of Vermont
- Heavy reliance on a global release of information (ROI)
 - Limited understanding and confusion on the IDN support of ROI development
- Change of leadership at VRH
- Lack of access to the Human Resource Department at VRH
- Job description and positing
 - Limited internal staff capacity to follow up on active applications and schedule for interviews.
- Limited staff capacity within the care coordination team
- Lack of development on assessment and referrals with internal and external partners
- Data points never discussed to track within the systems
 - Limitations to the data sharing regarding consent and non-covered entity participation
- Ability to leverage resources that had already existed in the community to help fulfill requirements
- Limitations to transparency of communication

Alternative Ideas and Ways to Move the Project Forward:

- IDN and Continuum of Care hosted transparent conversation with all community partners at the CPM meeting on February 7, 2018
- Allow community partners to identify areas of forward movement within the scope of work and use community knowledge to reframe and re-implement the project in Sullivan County
- Assess capacity and ability to host hiring and job posting to go through the IDN/ TDI/ DH
- Re-evaluate job description and determine minimum requirements to be beneficial to project
 - Assessment of licensure level needed
 - Benefits of a licensed social worker vs areas that can be filled by a lower level staff individual
- Opportunity for IDN funded administrative support and/or project management
- Work with VRH to assess for any areas of internal capacity for project ownership and support
 - Integration with B1 VRH/CA pilot
- Identify tools and systems that increase communication between project team, IDN, and UNH facilitator
- Assess options for further involvement of the community, potential development of a community advisory board
- Look at opportunities for hiring to originate from City of Claremont or others
 - Explore co-leadership for the coordinator position with VRH and another City organization
- Review project catchment area and expand for access in Newport, Claremont etc.- Sullivan County
 - Opportunities to coordinate with the Sullivan County CoC staff hired at DH
- Explore opportunities for lower level licensure to fill the CTC position and case examples
- Opportunity to link the CTC to B1 and use the MDCT as the referral source for patients to the E5
- Review supervision components and explore alternative options for coordination to provide supervision
 - Core components
 - Support requirements to the staff person
- Review caseload volumes and function
- Organizational assessment of behavioral health organizations- opportunities for linkage
- Speak to the DOC for coordination into a care management community network at point of release or discharge
 - Link to VRH for PC
 - Push to community supports network
 - IDN1 will be connected to the DOC for coordination
- Opportunity to use MCO data to pull patient panel and support identification for the community networks
 - Address capacity to link up to the ECC provided by MCOs and align with IDN projects

Lessons Learned:

- Early coordination with workforce is key to development
- Use the regional resource and expertise of those based in the region to share cultural insights
- Use the resource that is the network of providers in Sullivan County
- Strong benefit to the clearly defined project team roles

What can the IDN offer in support?

- QI Facilitation at all project team meetings
- Funding for PM support for the project
- Direct support at bi-weekly meetings
- Linkage to resource at the IDN level and coordination with IDN network partners

What is needed from a hosting agency?

- Staff time for project development and internal project management
- Commitment to continue funding for the coordinator
- Next steps: Define points of flexibility vs. what is set in regard to project structure

The restructuring and review of the E5 project is still underway with the IDN1 team, QI support, and CoC representative from Sullivan County.

Updates as of January-June, 2018:

Shortly after the submission of the December 31st SAR the IDN Admin team met for an internal strategic planning session to review the areas reported above from the strategic session undertaken with the pre-existing project team. The administrative team determined that for ease of restructuring the project ownership would be transferred back to the IDN team for the transition period. This required an internal review of time and costs accrued from the point of project award through point of return in January with VRH and IDN1. This process was mutually agreeable and resolved fully with a return of the 1st quarter payment.

The next steps determined by the IDN review was to continue to expand the project proposal awareness at the Sullivan County All Partners meeting. This meeting pulls together representatives from 35+ Sullivan County community support organizations, BH, hospital based staff etc. Since this group meets only once monthly, the IDN requested an additional hour be added to the meeting, a change which was favorably accepted by the membership. This full hour agenda period has allowed for considerable progress to be made over the course of a few short months.

In parallel the IDN Program Director assembled a small group steering committee to guide the restructuring. This small group consists of 2 CHI Coaches, the Sullivan County Substance Misuse Coordinator and as needed guest attendees. This group has been meeting bi-weekly to develop materials and work on the agenda/facilitation of the aforementioned All Partners session. The additional hour of this meeting is now referred to as the Sullivan County Complex Community Care Team (SCCT). In mid-March, 2018 once new foundation for the project development had been framed by the steering committee the group began targeted recruiting for a SCCT Facilitator to onboard as a contract position with IDN1. The guiding criteria were outlined as follows:

- Resident and Currently employed in a service role capacity in Sullivan County
- Active participant in the existing Sullivan County All Partners meeting

And the ability to adhere to the commitment below;

Task / Responsibility	Details	Time Required for Task Completion
Bi-Weekly Meetings	Held twice monthly with All Partners	2 hours / month Travel Set Up Time
Prep Call w/ IDN / CHI Team	To prep for Bi-weekly meeting	0.5 hours / month

Coordination of All Partners Meeting participants	Schedule meetings, secure meeting space, communicate with partners	1.5 hours / month
Support Partner Expansion and Inclusion	Reaching out to new partners, communications with new partners	.25 hours/month
Voice of the All Partner Group	External messaging, in support with the IDN and CHI.	.25 hours/month

This table was accompanied by the following email and shared with 3 selected candidates from the All Partners Group membership;

“Hope this email finds you quite well! I wanted to reach out to share some information about a new initiative underway in Sullivan County that I thought you may be interested in participating in and would be a great fit for. The Region 1 IDN is newly aligning with the All Partners Group that is currently meeting on the 1st Wednesday of the Month from 12:00-1:30pm alternating months at the Claremont Savings Bank and South Congregational Church in Newport. This large multi-stakeholder group is a meeting of direct care staff from Sullivan County and the surrounding area organizations who have been meeting for the last year to share resources. With support from the IDN the group will be adding time to their meetings to allow for a 1 hour community based care team meeting. This will function as a multi-organization case conference on previously identified high acuity patients. The group has not yet begun to share patients during the meetings but will be targeting de-identified patient sharing commencing in May/June 2018 as the team is supported by the IDN and privacy specialists to finalize the consent and ROI needs of the organizations participating. To lead the work forward over the next several months the project team working on the care team development are looking to identify a facilitator to lead the case conference sessions and serve as the team chair with support from the IDN1 staff, Quality Improvement coaches from CHI, and the Substance Misuse Coordinator for Sullivan County. The table below shows the estimated breakdown of time commitment and scope of work for the facilitator role. However, some of this is negotiable for the right person to fill the role. Additionally, it is anticipated that this role will be in place for 18 months with the potential to extend. The role will be financially supported by the IDN and 6 month evaluations will be built into the role to allow for additional support or alterations to the SOW as needed to accommodate for the expanding Care team group.”

In clearly framing out the time requirements, term commitment and the overview function of the role the E5 steering committee was able to confidently select a Facilitator. She works as the Community Support Liaison for the Newport School District and has a long history, understanding of the support service network in Sullivan County. The IDN team drafted and shared a contract for consultation to this individual that was accepted. Onboarding a facilitator to the project so early on in the restructuring felt very positive for the steering committee and has helped guide the development and shortened the implementation timeline.

The 1 pager below was created as a guidance document for the group membership and shared in spring, 2018:



REGION 1 IDN OVERVIEW

PARTNERSHIP FOR INTEGRATED CARE

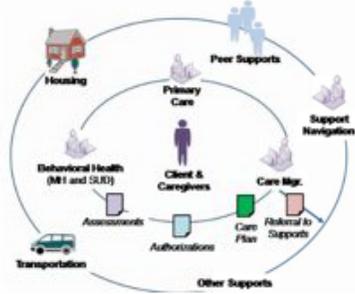
Overview
The Region 1 Integrated Delivery Network (IDN) is a partnership of almost 50 stakeholder organizations across the Upper Valley, Sullivan County, and the Monadnock Region committed to transforming the delivery of behavioral health services for Medicaid recipients by:

- Integrating physical and behavioral health care
- Expanding capacity to address behavioral health needs
- Reducing gaps in care transitions across care settings

Our diverse group of partners include:

- Advocacy groups
- Housing agencies
- Transportation services
- Municipal offices
- Clinical providers
- Substance use disorder centers
- Mental health workers

We embrace patient and family-centered care and want to foster collaborative and innovative pilot programs. We are hoping to advance integrated behavioral health and primary care service efforts in our region.



Administrative Team

Ann Landry, MBA, Executive Director
Peter Mason, MD, MPH, Medical Director
Jessica Powell, MA, Project Manager

E5 Project Team

Jessica Powell
Ashley Greenfield
Stacey Hammerlind

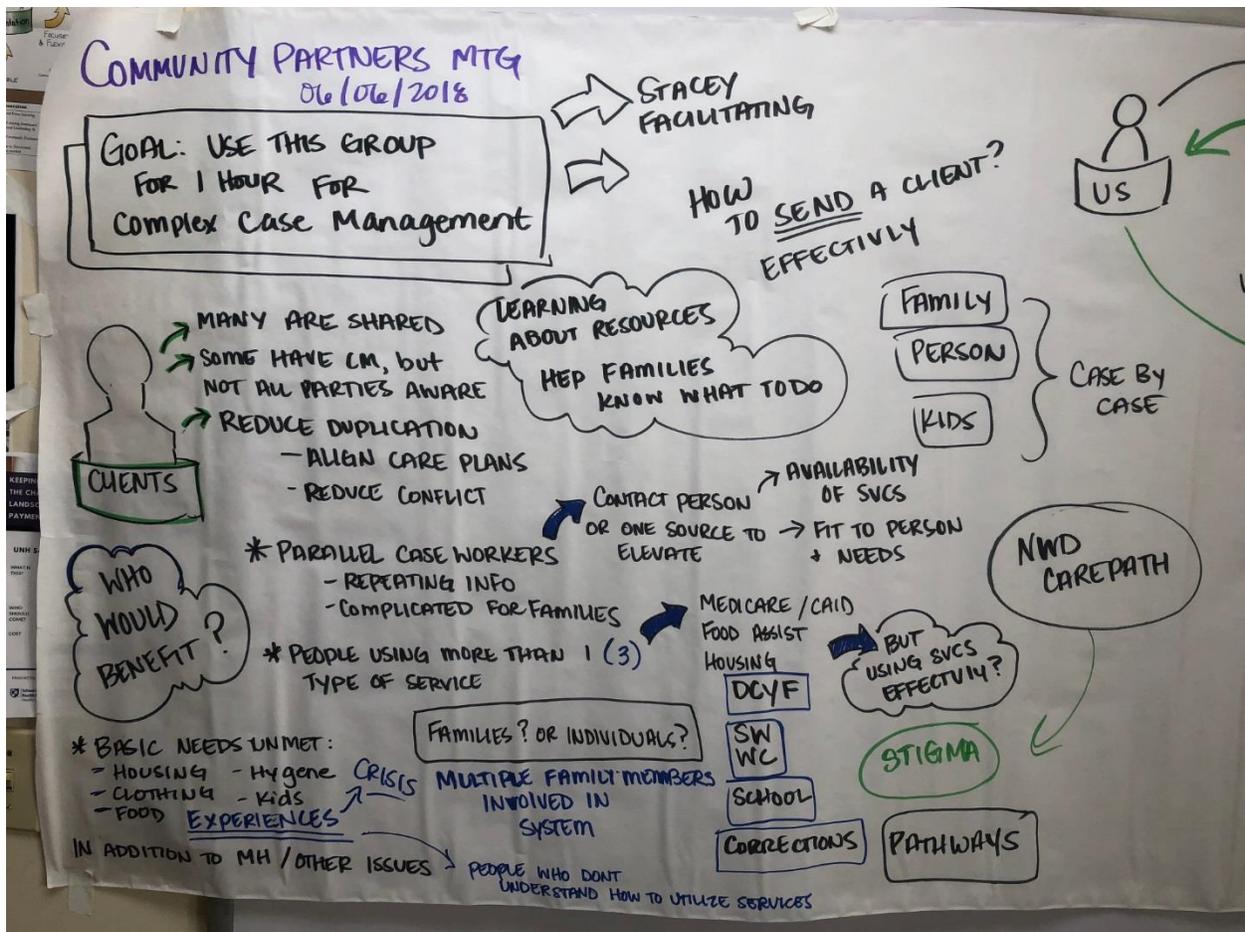


In the SCCT sessions March-June, 2018 the large group has given feedback on the following:

- Decisions regarding next steps of privacy/consent materials development
 - Each organization has noted a 1st point of contact for all consent items related to the SCCT ROI development
- Ranking on priority criteria for case referral to the SCCT
- Format and flow discussions on the # of cases, case information needed, and follow up closed loop processes

- Questions asked in a follow up planning survey:
 - How should individuals be referred to the Community Care Team? Please share your suggestions.
 - How much time should there be between a referral and the monthly Community Care Team Meeting?
 - Please share your suggestions on how client consent should be secured for the Community Care Team Meeting
 - How often should the Community Care Team Meet?
 - How many clients should be discussed during a 1 hour Community Care Team Meeting
 - What information should be shared during a standard case review?
 - Should a protocol be developed in case clients need to be discussed at more than one Community Care Team Meeting? Should there be a limit on how often a client or case can be discussed at the Community Care Team Meeting?
 - Add an open comment section at the very end. Please share any other feedback you would like taken into consideration.

The image below is one example of the visual facilitation undertaken with the large group during the SCCT sessions:



Additionally, a small group of 8 SCCT members was pulled together to review the following draft of a formatted referral document;

regi@n1 CITIZENS HEALTH INITIATIVE Case # _____

Community Care Team (CCT) Case Consultation Form

Date:	6/22/2018
Agency POC:	
Agencies Present:	LIST AGENCIES IN ATTENDANCE AT THE CCT MEETING

Demographic Information:

Household Members:	Age	Gender	Ethnicity/Race	Employment	Education	Marital Status	Primary Language

Income/Expense Sheet

Monthly Income	Monthly Expenses

Presenting Concerns (Check all that apply):

Housing	Utilities /Bills	Childcare			
Finances	Education	Employment			
Food/Meals	Physical Health	Social Isolation			
Transportation	Behavioral/Mental Health	Substance Use			

Notes:

regi@n1 CITIZENS HEALTH INITIATIVE Case # _____

Current Services and Supports:
Is the family/individual currently working with other providers, community agencies, or natural supports?

Agency Supports		
Agency	Type of Services	POC
School _____		

Natural Supports	
Relationship	Type of Support

Identified Strength(s):
What strengths has the client identified? What strengths do you identify?

Primary Case Consultation Question/Concern:
What are the primary concerns you are bringing to the Case Consultation Team (CCT)? What are the most pressing issues? How can the CCT assist?

An update of this form is underway and will be shared with the large group SCCT during the first week of August, 2018. This session of the SCCT will commence the first review of a de-identified case using the template format. The All Partners meeting reviews organizational programs with availability, resources, trainings etc. so there is a substantial group culture shift to incorporate individual case review. The E5 steering committee hopes to support the transition by starting slowly with 2-3 sessions run by the SCCT Facilitator of de-identified cases while in parallel the IDN team works to get a multi-agency consent form in draft format that meets all of the group’s needs. The hope is to keep these two workflows slightly separate since the direct members of the SCCT are direct care staff and, in almost all cases identified a separate person within their organizations to manage the privacy/consent discussions. Creation, vetting and implementation of the multi-agency consent will be a significant undertaking for the team over the next few months. It will be the first functional document of its kind in Sullivan County that bridges this grouping of organizations.

Commencing in fall, 2018 the SCCT will begin with monthly sessions to review 2 cases per session. This will allow the group to work through PDSA cycles on the following:

- Patient Centered Case Development
- Case Review Template
- Referral Follow up
- Patient Engagement

E-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list all of the progress toward targets or goals that the program has achieved. Targets required by the STCs include, but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

Given the early stage of project restructuring the large SCCT group has not had the opportunity to discuss project evaluation and the below are draft measures.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of Cases Reviewed by the SCCT	24 Cases (Annual)	N/A	N/A	
SCCT Referrals Made and Closed	100%	N/A	N/A	
Expansion of SCCT Membership	40 Organization	N/A	N/A	

E-3. IDN Community Project: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, document the current workforce staffing specifically related to this project using the format below.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
SCCT Facilitator	.5 FTE	N/A	N/A	Consultant Hired for Contract Hours up to 5 hrs. per Month	

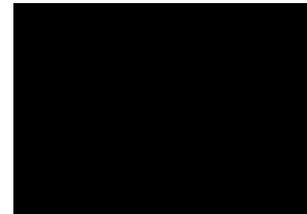
E-4. IDN Community Project: Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting.

No current project expenditures to date. Updated budget expenditures will be shared in the July-December, 2018 SAR. The current model is only incurring costs for the contracted SCCT facilitator’s time and drawing down on the contracted QI coaching hours previously contracted with CHI.

Previous expenditures for the E5 Coordinated Entry Project are reflected below as well as the E5 payments made to the C1/E5 Co-Pilot project as of June 30, 2018:

Enhanced Care Coordination - Total:
Valley Regional
Monadnock Family Services



Due to the current stage of implementation and deployment of the restructure E5 in Sullivan County for the Sullivan County Complex Community Care Team the IDN does not have enough understanding of how the project will be reseeded within the community organizations at time of reporting to project out expenditures through 2021. The E5 budgeted funds for overarching project category can be seen in the PPI budget on Pg. 11.

Updated projections for the Copilot C1/E5 project through CY2021. These budgets have been constructed to include all known components of IDN projects to date by CY but is subject to change as more details are determined in the upcoming implementation periods. Additionally, as IDN1 project subcontracts are created on implementation year and these focus on CY the balance of funds is slightly variable

Of note: the budget below is a hybrid for the combined C1/E5 project Co-Pilot. Funding for this project team is taken from both the C1: Care Transitions and E5: Enhanced Care Coordination Projects.

[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							

E-5. IDN Community Project: Key Organizational and Provider Participants

From Project A1: Workforce Capacity Development Implementation Plan, document the Key Organizational and Provider Participants specifically related in this reporting period to this project using the format below.

Given that the SCCT is functioning out of a pre-established network grouping there are not currently formal agreements in place with any of the participating organizations. As the project development progresses there will be executed consent forms will be executed with all of the participating organizations to facilitate identified case sharing. Additionally, it is the ultimate goal to re-seat project ownership within a Sullivan County-- based organization, at which time a subcontract agreement will be executed for project funding. Updates on the progress of these two formal agreements will come in subsequent reporting periods.

Organization/Provider	Agreement Executed (Y/N)
Baby Steps	N/A
Children of Incarcerated Parents	N/A
City of Claremont	N/A
Claremont Chamber of Commerce	N/A
Claremont Connect Center	N/A
Claremont Soup Kitchen	N/A
Colby-Sawyer College	N/A
DCYF	N/A
Department of Corrections, Sullivan County	N/A
DHHS	N/A
Episcopal Curate of Sunapee St. Andrew's, New London, NH, Epiphany, Newport, NH	N/A
Fall Mountain School District	N/A
Greater Sullivan County PHN	N/A
Green Mountain Children's Center	N/A
Groups	N/A
Groups	N/A
Headrest	N/A
Kearsarge School District	N/A
Lake Sunapee VNA and Hospice	N/A
New London Hospital	N/A
NH Employment Services	N/A
NH JAG	N/A
One for All SAU 6, Claremont	N/A
Pathways	N/A
Planned Parenthood	N/A
Regional Access Points	N/A
River Valley Community College	N/A

SAU 43- Newport	N/A
SAU 6- Claremont	N/A
Second Growth	N/A
ServiceLink	N/A
Shining Success	N/A
South Congregational Church, Newport	N/A
Southern NH Services	N/A
Southwestern Community Services	N/A
Sullivan County United Way	N/A
Sunapee School District	N/A
TLC	N/A
Tri-County Community Action	N/A
Turning Points Network	N/A
UNH Cooperative Extension	N/A
Valley Regional Hospital	N/A
Vital Communities	N/A
West Central Behavioral Health	N/A
Valley Regional Hospital	N/A
GROUPS Recover Together	N/A
Southwestern Community Service	N/A
SAU-6 FAST Forward 2020	N/A

E-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project

Given the early stage of project reconstruction the SCCT has not yet determined case assessment tools. It is anticipated that the group will look to use pre-existing community care team assessment standards as a guideline for the group's materials and tools development. Additional information will be shared in the December, 2018 SAR.

E-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

Updates as of June 30, 2018:

The IDN1 Administrative team is working with the SCCT E5 group to document their newly developed Care team protocols. A formal guidance document will be shared in winter, 2018.

Given the early stage of project reconstruction the SCCT has not yet determined protocols for patient assessment, treatment, management and referrals. Ongoing monthly large group brainstorm and work sessions are underway to lay the foundation for the assessment, management, referral and treatment flows to be adopted by all participating organizations.

Additional information will be shared in the December, 2018 SAR.

E-8. IDN Community Project Member Roles and Responsibilities

Use the format below to identify team members and their roles and responsibilities for the project. DHHS reserves the right to audit all or a selection of the written Roles and documents used by the IDNs.

Project Team Member	Roles and Responsibilities
[REDACTED]	Contracted Facilitator Responsibilities: Receipt of Case Referrals, SCCT Case Review Facilitation,
[REDACTED]	Substance Misuse Coordinator Support Responsibilities: Partnership Management and Project Support
[REDACTED]	Contracted QI Coach Responsibilities: Quality Improvement and Project Support
[REDACTED]	Contracted QI Coach Responsibilities: Quality Improvement and Project Support
[REDACTED]	Project Manager Responsibilities: Project Management Support

E-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3

Given the early state of project restructuring there has been no determined training or curriculum for the E5 SCCT beyond the developed materials shared in section E-1. It is anticipated that there will be a session dedicated to identifying training needed to support the transition to identified case sharing. Additionally, identification of any supportive trainings on large group care team dynamics, information sharing and case review are being pursued by members of the SCCT steering group.

DHHS Project Scoring: IDN Community Project Process Milestones

DHHS will use the tool below to assess each IDN's Community Projects activities. Grayed areas indicate that no submission is expected for the time frame. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
E -1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
E -2	IDN Community Project Workforce Staffing	Table				
E -3	IDN Community Project Evaluation Project Targets	Table				
E -4	IDN Community Project Budget	Narrative and Spreadsheet				
E -5	IDN Community Project Key Organizational and Provider Participants	Table				
E -6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
E -7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
E -8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				
E-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

Lynn Guillette, VP of Payment Innovation at Dartmouth Hitchcock and Chair of the IDN1 Executive Committee, has been named the primary IDN1 APM liaison for the DHHS sponsored APM workgroup. Lynn, one of the leaders in the state on alternative payment models, has been integrally involved in IDN1 activities since the projects inception and served on the Exec. Committee and as chair of the IDN1 Finance Committee. The IDN1 Finance Committee under Lynn's leadership in January/February, 2018 has been relaunched to shift focus to determining the regional APM strategy and tracking alignment to the statewide plan developments.

Given the current status of the statewide APM roadmap the IDN1 team is also in the beginning stages of plan development. IDN1, along with other IDNs, are watching the MCO procurement carefully to better understand what the shared responsibility between MCOs and the IDNs will be in developing the APM strategy and defining the "50%". The IDN1 team feels that with the workgroups strong membership and regional knowledge expertise this group will be successful in driving the regional plan forward and maintaining coordination with statewide efforts even in the short timeframe required. Additional information on the regional IDN1 APM plan development will be available in subsequent SAR reports.

APM-1. Project APM Scoring: IDN Participation in Statewide APM Taskforce and Implementation Plan Development and IDN APM Implementation Plan

Provide a brief narrative describing the current use of APMs among partners.

Use the format below to: identify the IDNs participation in workgroups for the development of the DSRIP APM Implementation Plan; assess the current use and/or capacity for engaging APMs amount IDN participants; develop an IDN-specific plan for implementing the roadmap to include IDN-specific outcome measures; and develop the financial, clinical and legal infrastructure required to support APMs.

Currently in IDN1 there are several organizations accessing APM structured contracts with NH state insurers of Medicaid recipients. Most notably are those pre-existing contracts with the Community Mental Health Centers; West Central Behavioral Health and Monadnock Family Services. As well as those between hospital systems such as Dartmouth-Hitchcock through their ACO work and contracted services.

At this point in state IDN APM development there are no IDN1 partners with APM contracts. The IDN1 team is staying tightly connected to the MCO Procurement process and aligning where possible to extend the

current APM structures in place with network partners and addressing new areas of coordination. Additionally, the IDN team is staying closely involved with the development of the DHHS APM Roadmap to guide new APM opportunities for our network partners.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Met	Met	
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures	Met	Met	
Develop the financial, clinical and legal infrastructure required to support APMs	In Process, Fully Supported by IDN1	In Process, Fully Supported by IDN1	
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	Met	Met	

DSRIP Outcome Measures for Years 2 and 3

Each IDN may earn up to 10% of the total IDN performance funding in Year 2 (CY 2017) and 25% of the total performance funding in Year 3 (CY 2018). The Table below, provided for information only, includes the DSRIP Outcome Measures that will be used for incentive payments for Years 2 and 3. For Years 2 and 3, use the current DSRIP Outcome Measures that must be reported as indicated in the Table below; cross reference to the final DSRIP Outcomes Measures documentation, located in eStudio. For additional information regarding Years 2-5 incentive payment mechanics, see the STCs, Attachment D, located in eStudio.

For Years 4 and 5, CY 2019 and 2020, 100% of the performance funding will be based on the DSRIP Outcomes Measures. See the DSRIP Outcomes Measures, available on the DSRIP website, for more information.

DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	Year 3 (CY 2018)	
	Incentive Payment for Reporting Measures	Incentive Payment for Performance Improvement Measures
Use of Comprehensive Core Standardized Assessment by Medicaid Billing IDN Providers	Recommended U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by IDN Providers (reporting)	Physical Health-Focused HEDIS Measures for BH Population: Summary Score (reporting)
Appropriate Follow-Up by Medicaid Billing IDN Providers for Positive Screenings for Potential Substance Use Disorder and/or Depression	Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by Medicaid Billing IDN Providers (reporting)	Experience of Care Survey: Summary Score
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners	Timely Transmission of Transition Record After Hospital Discharge (reporting)	Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Develop an IDN-specific roadmap for using APMs	Potentially Avoidable Emergency Department Visits
		Follow-up After Emergency Department Visit for Mental Illness Within 30 Days
		Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days
		Follow-up After Hospitalization for Mental Illness Within 7 Days
		Follow-up After Hospitalization for Mental Illness Within 30 Days
		Extended Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose

Appendix A1-3:

Deliverable/Milestone	Pre	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Status	December 2017 Notes	June 2018 Notes
<i>Continued Participation in Statewide BHWT</i>														Ongoing	Continued Statewide Collaboration in small groups and at the taskforce level	
Deliverable: Submission of Statewide BHWT Strategic Plan														Completed		
Deliverable: Signed Attestation of IDN Review and Acceptance of BHWT SP Signed by Peter M. and Will T. as Region 1 Representatives														Completed		
Deliverable: Implementation Timeline														Completed		
<i>Phase 1 : Through December 2018 (Detailed)</i>																
<i>Phase 2: End of Implementation Plan (High-Level)</i>																
Milestones																
High level Milestones through 2020																
Deliverable: Milestones Timeline														Completed		
Evaluation Metrics and Targets																
Deliverable: Identify measurable targets and goals to align with Milestones timeline														Completed		
Strategy Development																
Deliverable: Workforce Capacity Development Strategy														Completed		
Address Education and Training Completion to Readiness																
Address Data/Initiative inventory assessment																
Staffing/ Recruitment																
Identify FTE needs across A2, B1, C1, D3, E5														Completed		
Include Workforce FTE strategy and Projections for unknown areas														Completed		
Deliverable: Fill SA Staffing Table														Completed		
Share Table with All Project Partners and AC														Completed		
Schedule HR Meeting with Region 1 IDN Partners														Completed		
HR Meeting with Region 1 IDN Partners: Address data sharing, recruitment, cost of hiring, position vacancies														Completed	Met with a few partners individually; Met with multiple partners during November and December workforce meetings; HR meeting scheduled for January was pushed back to February	Conducted HR meeting in February which served as a training for best practices for behavioral health workforce recruitment and retention strategies.
Schedule Meeting with IDN Partner Clinical Directors and Center for Technology in Behavioral Health at DH														Completed		
Clinical Partners and CTBH Meeting on innovative recruitment and utilization of remote clinicians														Completed		
Support creation of a Teleconferencing Supervision Committee to address potential for group and teleconference based clinical supervision														Completed		
																Region 1 IDN Workforce Workgroup didn't wish to hold a Region 1 IDN specific job fair. Partners struggle with

Deliverable/Milestone	Pre	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Status	December 2017 Notes	June 2018 Notes
Regional Job Fair, 2017: Targeting students graduating in Spring of 2018 (Recurring 1x Annually) Change Deliverable: Leverage and communicate about existing job fairs in each sub-region to ensure partners are represented at them to promote behavioral health positions														In progress	IDN is working with partners to select spring time date; IDN is also working with all other IDNs on a statewide strategy to celebrate behavioral health sector which would include job fairs and mental health days	Region 1 IDN Workforce Workgroup didn't wish to hold a Region 1 IDN specific job fair. Partners struggle with the effectiveness of job fairs in general, attending only out of obligation and the ROI may result in one new applicant. The group recommended leveraging existing job fairs, communicating existing job fairs, exploring an all – IDN virtual job fair and participating in a statewide job fair if hosted.
"Trailing Partners/Spouses" Policy Planning Meeting with Region 1 Partners: Targeting process and IDN support for developing recruitment strategies for partners and families of high need BH positions														Completed	Met with a few partners individually; Met with multiple partners during November and December workforce meetings; HR meeting scheduled for January was pushed back to February; Next steps include meeting with HRs in non-healthcare organizations to create unified strategy across sub-regions	
Inclusion of Single Point Information for BH positions on loan repayment, available positions, and other incentives: Linkage to Region 1 Website, State and Workforce Sites														In progress	Region 1 IDN is going to shift focus to creating an overarching social marketing strategy locally and in conjunction with the statewide plan; this social marketing strategy will include a local website campaign that makes this information accessible	Region 1 is still modifying approach given the inherent challenges of creating a centralized strategy for three sub-regions.
Include BiState Primary Care on all Regional Workforce Meetings														Completed		
Region 1 Medical Director will attend all Governors Primary Care Commission Meetings														Completed		
Region 1 support for Statewide initiatives addressing barriers in BH licensing processes														Completed		
Continued support and funding for Region 1 Loan Repayment Initiative: In alignment with State of NH BH Repayment Initiatives														In progress	Region 1 waited to learn more about how it could support the statewide initiative including financially. As the reporting period continued, it became more clear that Region 1 should create its own local loan repayment program. This will be reflected in the pending Request for Award for general workforce funds to be released early in 2018.	Region 1 IDN offered \$82,500 towards Loan Repayment its Phase I Workforce RFA and approved all \$70,000 requested. Additionally, Region 1 offered \$7500 in loan repayment incentive dollars for one B1 team to recruit the licensed social worker and will incorporate this incentive moving forward. This milestone will always be in progress.
Develop a supervision plan to meet the needs determined by the Supervision Committee convened in Fall, 2017														In progress	The Region 1 Workforce Workgroup is focused on a Supervision Plan and has carved out part of its meetings to create this plan; an ad hoc group will meet as needed.	Region 1 IDN offered \$62,500 towards Supervision Programming/Organizational Capacity for Supervision in its Phase I Workforce RFA and approved all \$40,585 that was appropriately requested. Region 1 IDN operations team will look for feedback from the awardees on what works and will continue to address at Workforce Workgroup meetings.
Scheduled Semi-Annual HR Directors Meetings in Region 1: Addressing ongoing																IDN 1 conducted first semi-annual HR meeting in February which served as a training for best practices for behavioral health workforce recruitment and retention strategies. IDN1 will continue to schedule

Deliverable/Milestone	Pre	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Status	December 2017 Notes	June 2018 Notes
Scheduled Semi-Annual HR Directors Meetings in Region 1: Addressing ongoing challenges and success of Region 1 Workforce efforts														In progress		IDN 1 conducted first semi-annual HR meeting in February which served as a training for best practices for behavioral health workforce recruitment and retention strategies. IDN1 will continue to schedule these meetings on a semi-annual basis.
Assess Website - One Point Information for BH Positions Use at 6 Month Intervals														In progress		See Row 36 for detailed explanation. Region 1 IDN Workforce Workgroup didn't wish to post organization job postings on website; instead Region 1 IDN has measured hits on Region 1 IDN website. The team specifically is driving partners to the training and resources pages. Total Hits: Jan: 3941
Joint "Trailing Partner" recruitment strategy finalized and shared with all adopting Region 1 Partners														In progress		IDN 1 is in communication with River Valley HR Association to discuss the trailing spouses strategy. The team is trying to get on an upcoming agenda by fall of 2018. Additionally, discussions have ensued at the Statewide Workforce Taskforce about creating a statewide strategy for a trailing spouses program.
Implementation of Supervision Plan																
Operationalize Recruitment with Regional Employers																
Applications Accepted for Loan Repayment														In progress		Region 1 IDN offered \$82,500 towards Loan Repayment its Phase I Workforce RFA and approved all \$70,000 requested. Additionally, Region 1 offered \$7500 in loan repayment incentive dollars for one B1 team to recruit the licensed social worker and will incorporate this incentive moving forward. This milestone will always be in progress.
Budget																
Deliverable: Building Capacity Budget														Completed		
Inclusion of all expected, anticipated/projected expenses																
Develop and Support Budget Tables for all Project Pilots																
Inclusion of reporting and update milestones for budget reporting																
Build in Measurement for Payment Cycle																
Provide ongoing Budget updates through financial reporting on actual spending																
Develop Budget component of Sub-contract agreements																
Deliverable: Table of Key Organizational and Provider Participants														Completed		
(Include Provider List across all Partners (A, B, C1, C2, C3))																

Deliverable/Milestone	Pre	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Status	December 2017 Notes	June 2018 Notes
<i>Include Partner List across all Projects (A2, B1, C1, D3, E5)</i>																
Retention																
Training Program Development: Address Culture of change and integration of the cultures of physical and behavioral health														Completed		
Schedule Community forums in each sub-region of the IDN 1 Catchment: Follow similar model to Mental Health Day Program at DHMC Change Milestone to Leverage existing community forums in each sub-region to promote mental health awareness and inform about the IDN work; partner with other IDNs on a statewide approach														In progress	Region 1 focused on recruitment and staffing for projects during this past reporting period, deciding to move the Community Mental Health forums to the spring. Additionally, Region 1 is creating an overarching social marketing strategy/campaign for the region which will include Community Mental Health Forums as well as align to the statewide workforce taskforce behavioral health celebration and job fairs	Partners represented on the Region 1 IDN Workforce Workgroup determined that IDN sponsored community forums would be redundant and a poor use of resource. The group recommends leveraging and supporting existing community forums to celebrate progress and mental health/SUD. Additionally, the group believes that this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan.
Schedule meetings with regional community mental health providers: Target level of supportive funding to provide necessary support for career advancement and reduce burn-out														Completed		
Target determining thresholds for Salary/Benefits through Monthly Knowledge Exchange Workforce Meetings														Completed		
Activities by Workforce Workgroup to explore supportive funding synergies: philanthropy, development etc. - Quarterly Ongoing.														Completed		
Supported Culture of Change Trainings for B1 Partner Agencies (available for all IDN partners) - Assess Progress Semi-Annually														Completed		IDN 1 will offer additional culture of change trainings in the latter half of 2018. In process of trying to identify other effective trainings that have been successful for other IDNs.
Supported Community Forum Meetings across IDN 1 - Assess progress Semi-Annually in 2018 Change Milestone to Assess progress semi-annually in 2018 on success in Leveraging existing community forums in each sub-region to promote mental health awareness and inform about the IDN work; partner with other IDNs on a statewide approach														In progress	Region 1 focused on recruitment and staffing for projects during this past reporting period, deciding to move the Community Mental Health forums to the spring. Additionally, Region 1 is creating an overarching social marketing strategy/campaign for the region which will include Community Mental Health Forums as well as align to the statewide workforce taskforce behavioral health celebration and job fairs	See Row 64. Partners represented on the Region 1 IDN Workforce Workgroup determined that IDN sponsored community forums would be redundant and a poor use of resource. The group recommends leveraging and supporting existing community forums to celebrate progress and mental health/SUD. Additionally, the group believes that this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan.
Operational IDN partner staff salary support addressing entry-level positions supplemental funding																Region 1 IDN offered \$137,500 towards Entry Level Position Support its Phase I Workforce RFA and approved all \$83,900 requested. This milestone will always be in progress.
Ongoing data evaluation and assessment of retention impact on the positions and organizations supported through the entry-level positions supplemental funding program																

Deliverable/Milestone	Pre	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Status	December 2017 Notes	June 2018 Notes
Additional supported community forums, emphasizing mental health topics will be scheduled as requested																
Education Activities and Milestones																
Identification of partnering regional educational institutions interested in developing new, and enhancing existing, behavioral health training programs														In progress	Ongoing in conjunction with Statewide Workforce Training & Education Subgroup	Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC
Region 1 IDN Meeting with NH AHEC: Strategy development about enhancing educating student health professionals in collaborative practice and team-based														Completed		
Region 1 IDN and Partner Meeting with NH AHEC: Development of a "Road Show" promoting behavioral health career paths- First Meeting Completed														Completed		
Region 1 IDN Meeting with NH BDAS, Recovery Coach Academy, Center for Excellence, and other IDN's: Strategy development to address expanding the pool of peer recovery coaches in the Region and across the State														Completed		
Region 1 IDN Develops assessment with partner organizations to assess capacity for expanded student and trainee internships, preceptorships, and electives														In progress	Workforce Workgroup and all-partner Workforce discussion continues to discuss this topic and how to facilitate increased capacity for students and "apprentices"	Region 1 IDN offered \$75,000 towards Internship Stipends and Organization Capacity to Support Internships in its Phase I Workforce RFA and approved all \$35,000 requested. The IDN is also always discussing how to sustain the ability to fund and support interns given the importance of fueling the pipeline while recognizing the financial cost and resource drain on organizations. This milestone will always be in
Functional workgroup of participating student and trainee internship supported agencies - Meeting quarterly														In progress	Region 1 Workforce Workgroup has discussed how to financially support IDN partners with encouraging internship opportunities - both funds to support intern stipends and funds to support organizations to train/supervise interns. However, Region 1 has yet to release funds to partner agencies. Region 1 will continue to embed this discussion quarterly at the standing Workforce Workgroup discussions.	Region 1 IDN offered \$75,000 towards Internship Stipends and Organization Capacity to Support Internships in its Phase I Workforce RFA and approved all \$35,000 requested. The IDN is also always discussing how to sustain the ability to fund and support interns given the importance of fueling the pipeline while recognizing the financial cost and resource drain on organizations. This milestone will always be in progress. Interns have just been brought on this summer through IDN-funding.
Meetings held with administrative and behavioral health faculty staff at Keene State, New England College, Antioch New England, Colby- Sawyer College, River Valley Community College and Franklin Pierce University: Regarding educational programs to address regional workforce needs - Completion by June 2018														In progress		Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC
Coordinate meetings with IDN and NH AHECS- Address development of an inter-professional collaborative practice curriculum to be utilized by NH professional schools - Explore opportunities such as utilizing an interactive computer module.														In progress		Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC
Creation of comprehensive list of student and trainee sites developed and shared																Interns have just been brought on this summer through IDN-funding. Additionally, this should be a statewide

Page 2

Deliverable/Milestone	Pre	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Status	December 2017 Notes	June 2018 Notes
Creation of a comprehensive list of student and trainee sites developed and shared														Not Started		Interns have just been brought on this summer through IDN -funding. Additionally, this should be a statewide goal.
Regional educational institutions involved in subsequent education activities will finalize identification of opportunities for new and expanded workforce development programs- Draft completion by December, 2018																
IDN supported additions to the student and trainee sites offered																
Continued development and progress on the inter-professional collaborative practice curriculum developed																
Training Activities and Milestones																
Region 1 IDN Meeting with B1 Providers- Address Workforce components of the Integration Project and IDN Supports														Completed		
Region 1 Supported information gathering to address partner desired trainings, current in house trainings, capacity for expansion, ability for new training creation, and the number of existing staff interested in each training category														Completed		
Offer trainings for Billing and Administrative Staff across all B1 partner agencies, other IDN interested partners, on mental health, SUD, and health literacy topics														In progress	To be started in 2018; looking at opportunities to align with Statewide Taskforce and other IDNs	Region 1 funded West Central Behavioral Health to offer 6 Mental Health First Aid Trainings in the Upper Valley and Sullivan County in 2018. Region 1 is working with Monadnock Family Services to offer a series of Mental Health Awareness trainings across the
Offer trainings for clinical staff on Universal SBIRT usage and Motivational Interviewing														In progress	All of our partners have access to the CHI/JSI SBIRT MI Initiative but we will encourage further training in the next year	All of our partners have access to the CHI/JSI SBIRT MI training on July 25th and then a two part training scheduled for September 25th and October 2nd.
Schedule trainings for assessing MAT expansion capability across IDN partner primary care sites - Assess progress across providers														In progress	Medical Director is currently piloting program at the Multispecialty Clinic at Alice Peck Day Memorial Hospital.	Medical Director is currently piloting program at the Multispecialty Clinic at Alice Peck Day Memorial Hospital and about to roll out to primary care practices across the state.
Support trainings for all Pt 2 providers on updated 42 CFR Pt. 2 requirements- Align with any Statewide or Learning Collaborative supports - Assess progress across														Completed		
Region 1 Meetings with Center for Behavioral Health Technology to explore use of telehealth models; Expanded treatment capacity and leveraging in-region BH expertise - Assess progress														Completed		
Support dissemination of the "Know the Five Signs" program through changedirection.org/NH														In progress		Region 1 is working with Monadnock Family Services to offer a series of Mental Health Awareness trainings across the entire region - this has a focus on "Know the Five Signs" program.
Begin implementation of new self-management programs																
Schedule Region-wide training sessions in cultural competency														Not Started		

Deliverable/Milestone	Pre	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Status	December 2017 Notes	June 2018 Notes
Begin implementation of new self-management programs																
Schedule Region-wide training sessions in cultural competency														Not Started		
Schedule Region- wide training sessions in suicide prevention														Not Started		
Progress and expansion of Region 1 IDN Primary Care capacity to offer MAT														In progress	Medical Director is currently piloting program at the Multispecialty Clinic at Alice Peck Day Memorial Hospital and about to roll out to primary care practices across the region and state.	
Assess progress made across IDN 1 providers on SBIRT/MI Trainings														In progress		
Support dissemination of the "Know the Five Signs" program through changedirection.org/NH																
All Region 1 B1 providers have completed the SBIRT and MI training																
All Region 1 B1 Providers Billing, Administration staff trained in MH and SUD																
All IDN partner staff have had access to suicide prevention and cultural competency																

Page 3

Appendix B1-2: DH-Heater Rd and WCBH

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Completion	Status
Implementation Year 1	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
Charter Completion- Final review and approval by all project team members					Sept.	Nov.	Complete
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month							Met
Team Meetings							
Set up recurring bi-weekly meetings at alternating site locations to support attendance across organizations					Completed		
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps					Oct.	mid-Nov.	Complete
Support and document MDCT meetings monthly and case assessment process					Dec.	Ongoing	Complete
Recruit to Hire - M1, 2							
Document weekly progress toward position hiring and share with broader project team membership					Ongoing/Complete		
Share job descriptions and links to postings with all project team members					Ongoing/Complete		
Assign team member lead support for communication of progress and interview panel updates					Ongoing/Complete		
Onboarding							
Formalize and document the onboarding and training process					Oct.	mid-Nov.	Complete
*Share with all project team members and address willingness to share with other programs							Met
Create a training plan by needed position to share and replicate for subsequent hires					mid-Nov.	Dec.	Complete
*Address privacy and consent training for role within IDN SCP							Met
Address with project team onboarding activities to be supported by the IDN staff and partner network					Oct.	mid-Nov.	Complete
Training							
Train clinical staff in administration and use of CCA systems							

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Completion	Status
Implementation Year 1	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
Training							
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities							Complete
Train MDCT in roles and responsibilities							Complete
Train MDCT in use of SCP and secure messaging							Complete
Train community partners in use of SCP and secure messaging							Complete
Train patients and families in use of SCP- IDN Supported							Complete
Determine physical health, mental health and SUD topics for MDCT training							Complete
Decide on standardized, evidence-based training materials							Complete
Develop training schedule, including update schedule							Complete
Train all staff in cultural sensitivity and destigmatization							Complete
Offer annual training to all project team membership on chronic disease management in the following domains:							Complete
Diabetes Hyperglycemia							Complete
Dyslipidimia							Complete
Hypertension							Complete
Mental Health Topics (Multiple)							Complete
SUD Topics (Multiple)							Complete
Offer basics of mental health first aid to practice billing and reception staff annually							?
* Address training funding capacity through current project funding, current systems to leverage and opportunities for alignment with the IDN1 workforce priority areas							
Target Population-M2							
Create a registry of Medicaid beneficiaries at D-H Heater Rd and West Central Behavioral Health							Complete
Create a registry of Medicaid beneficiaries with documented							

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Completion	Status
Implementation Year 1	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems and current relationship with WCBH							Complete
Create a list of the patients who are seen most frequently for behavioral/mental health problems							Complete
Create a sub-list of patients with documented SUDs, including substance(s)							Complete
<u>Process Mapping and Patient Flows</u>							
Complete intake and screening process at WCBH							Complete
Finalize patient flow at both onboarding patient sites - WCBH, Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision							Complete
<u>Process Milestones and Reporting</u>							
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM							Complete
Finalize operational dashboard for measures and measure collection							Complete
Present to larger project team for approval and finalization							Complete
Address IDN required data reporting and document reporting ownership with the project team. Identify lead and support for data and process reporting to the IDN							Complete
Continuously collect and interpret outcome data- M3							
Review pledged project outcomes with all partners							Complete
Schedule quarterly project outcome review							Complete
Schedule quarterly report targets and deadlines							Complete
Analyze and review 6 months of project outcomes -M4							Complete
Review and assess potential supplemental funding opportunities - M4							Complete
*Focus on project sustainability							

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Completion	Status
Implementation Year 1	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
Comprehensive Core Standardized Assessment							
Continue CCSA development and coordination with DH SDOH taskforce							Complete
Training across B1 teams on CCSA Implementation							Complete
Crosswalk these domains with existing demographic, SDOH, and screening instruments currently in use							Complete
Integrate finalized CCSA into existing EMR							Complete
Integrate CCSA into workflow							Complete
Address coordination with WCBH utilization of DLA20							Complete
Produce and finalize documentation with project team attesting to the tools in use across the project team and crosswalk to IDN determined domain areas							Complete
Comprehensive Core Standardized Assessment (Pediatric)							
Determine the developmental screening instrument to be utilized with the CCSA							Complete
Integrate developmental screening into existing EMR				Ongoing			Complete
Integrate developmental screening into workflow							Complete
Shared Care Plan							
Project team demo on SCP portal and needs							Complete
Address inclusion of non covered entities on SCP							Complete
* Look to Legal/Privacy for required consent, next steps and training							
Budget							
Establish use of funds tracking for pilot within current system -							Complete
*Address unique DGR project code for salaries and							
Create funding matrix to show IDN funded areas and other supported positions, activities							Complete
Establish use of funds tracking and budget table							Complete
Share quarterly with IDN							Complete
Key Organizational and Provider Participants							

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Start	n	Status
Implementation Year 1	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
0 Key Organizational and Provider Participants							
1 Share formal award notice to all partners and supporting organizations							Complete
2 Document and continually support referral partnerships							Complete
3 Address any gap areas in partner support network- target through new partner cultivation							Complete
4 Address cultural barriers and look to supported IDN trainings on culture change							Complete
5 Network Development - M2, M3							
5 Project team review and identification of all formal project partners and community supports							Complete
7 Assign team members to support development and outreach							Complete
3 Continue to expand and develop the network of collaborating organizations							Complete
9 Review current process for developing new partner relationships							Complete
0 Privacy & Security							
1 Train Staff on Treatment of Sensitive Patient Information							Complete
2 Execute Data Sharing Arrangement with Support Services Organizations -M2							Ongoing
3 *Identify areas where updates or new development is needed							
4 Linkage to IDN resources and forms							Ongoing
5 HIT Implementation							
5 Deploy Shared Care Plan Application							Complete
7 Deploy Direct Secure Messaging Application							Complete
3 Deploy Event Notification Application							Complete
9 Deploy Clinical Quality Measurement Application							?
0 HIT Components Completed and Functional - M2, M3							Complete
Utilize the IDN supported technology based systems to track							

Sheet1

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Completion	Status
Implementation Year 1	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup							Complete
Integration Assessment							
Complete SSA at 6, 12, 18 month intervals							Complete
Project team coordination for SSA completion, submission, and review							Complete
Evaluation							
Review for inclusion of evidence based practices determined in implementation plan							Complete
At 6 month intervals (12/31/17, 6/30/18, 12/31/18) measure							Complete
# of external community support referrals from B1 team							? (not sure this is be
Progress towards coordinated care practice designation							Complete
Data Sharing							
Outcome data accumulated and reviewed							Complete
Approve and disseminate data sharing forms to all project							Complete
Share SSA Integration levels with B1 provider cohort							Complete
*Support IDN efforts for data transparency through reporting and project outcomes presentation							
Meetings and Reports							
Documented minimum requirement met quarterly							Complete
Knowledge Exchanges and IDN Involvement							
Share key learnings with IDN1 partners and participation							Complete
Use of Funds							
Appropriate use of project funds used monthly and actuals reported quarterly							Complete
Accountability of Time							
Accountability for use of staff time to serve project functions reported quarterly							Complete

Appendix B1-2: VRH and CA

Deliverable/Milestone	PRE-Q1	Q1	Q2	Q3	Q4	Status	Notes
IMPLEMENTATION YEAR ONE	11/17-12/17	1/1/18-3/30/18	4/1/18-6/30/18	7/1/18-9/30/18	10/1/18-12/31/18		
Meeting with QI facilitator & IDN leadership and Counseling Associates to launch project						Complete	Meeting set for December 19, 2017
Complete contracting process and submit						Complete	
Create MSW job description						Complete	
Begin advertising for RN in VPC (VRH funding)						Complete	
Identify B1 work team members						Complete	
Identify ongoing work team meeting dates/time						Complete	
Meeting with VPC team for introduction of project						Complete	Meeting set for Jan 10, 2018; 12:00-1:30
Meet and Greet for VPC staff and providers with Counseling Associates staff						Complete	Meeting set for Jan 10, 2018; 1:00-1:30
Identify Role for AmeriCorp member(s) and confirm						Complete	
Charter Completion- Final review and approval by all project team members						Complete	Uploaded to Box
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month							
Team Meetings							
Set up recurring bi-weekly meetings and support attendance across partner agencies						Complete	Uploaded to Box
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps						Complete	Uploaded to Box
Support and document MDCT meetings monthly and case assessment process						Complete	
Recruit to Hire							
Document weekly progress toward position hiring and share with broader project team membership						Complete	MSW hired
Share job descriptions and links to postings with all project team members						Complete	
Assign team member lead support for communication of progress and interview panel updates						Complete	
Onboarding							
Formalize and document the onboarding and training process for new positions						Complete	MSW completed series of training

Deliverable/Milestone	PRE-Q1	Q1	Q2	Q3	Q4		
*Share with all project team members and address willingness to share with other							
Create a training plan by needed position to share and replicate for subsequent hires						Complete	
*Address privacy and consent training for role within IDN SCP							
Address with project team onboarding activities to be supported by the IDN staff and partner network						Complete	
Training							
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities						Ongoing	
Train MDCT in roles and responsibilities						Ongoing	
Train MDCT in use of SCP and secure messaging						Ongoing	
Train community partners in use of SCP and secure messaging						Ongoing	
Train patients and families in use of SCP- IDN Supported						Ongoing	
Determine physical health, mental health and SUD topics for MDCT training						Ongoing	
Decide on standardized, evidence-based training materials						Complete	
Develop training schedule, including update schedule						Ongoing	
Train all staff in cultural sensitivity and destigmatization						Ongoing	
Offer annual training to all project team membership on chronic disease management in the following domains:						Offered through IDN1	
Diabetes Hyperglycemia							
Dyslipidemia							
Hypertension							
Mental Health Topics (Multiple)							
SUD Topics (Multiple)							
Offer basics of mental health first aid to practice billing and reception staff annually							
* Address training funding capacity through current project funding, current systems to leverage and opportunities for alignment with the IDN1 workforce priority areas							
Target Population-M2							
Create a registry of Medicaid beneficiaries at VRH Primary Care and Counseling Associates			underway			Ongoing	
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems and current relationship with WCBH						Ongoing	
Create a list of the patients who are seen most frequently for behavioral/mental health problems						Ongoing	
Create a sub-list of patients with documented SUDs, including substance(s)						Ongoing	
Process Mapping and Patient Flows							
Complete intake and screening process at VRH, CA			underway			Ongoing	
Finalize patient flow at both onboarding patient sites - VRH, CA			underway			Ongoing	
Address other mapping with teams- communication flows through SCP, role of CTC within						Not Yet Started	

Deliverable/Milestone	PRE-Q1	Q1	Q2	Q3	Q4		
Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision points							Not Yet Started
Process Milestones and Reporting							
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM						Complete	This is listed at the bottom of all meeting agendas.
Finalize operational dashboard for measures and measure collection						Complete	
Present to larger project team for approval and finalization						Complete	
Address IDN required data reporting and document reporting ownership with the project team. Identify lead and support for data and process reporting to the IDN						Complete	
Continuously collect and interpret outcome data						Ongoing	
Review pledged project outcomes with all partners						Ongoing	
Schedule quarterly project outcome review						Scheduled	
Schedule quarterly report targets and deadlines						Scheduled	
Analyze and review 6 months of project outcomes						Ongoing	
Review and assess potential supplemental funding opportunities						Ongoing	
*Focus on project sustainability							
Comprehensive Core Standardized Assessment							
Training across B1 teams on CCSA Implementation			✓			Complete	Uploaded to Box
Crosswalk these domains with existing demographic, SDOH, and screening instruments currently in use			✓			Complete	
Integrate finalized CCSA into existing EMR			underway			Ongoing	
Integrate CCSA into workflow			underway			Ongoing	
Produce and finalize documentation with project team attesting to the tools in use across the project team and crosswalk to IDN determined domain areas						Complete	
Comprehensive Core Standardized Assessment (Pediatric)							
Determine the developmental screening instrument to be utilized with the CCSA						Complete	
Integrate developmental screening into existing EMR						Ongoing	
Integrate developmental screening into workflow						Ongoing	
Shared Care Plan							
Project team demo on SCP portal and needs						Complete	
Address inclusion of non covered entities on SCP						Ongoing	
* Look to Legal/Privacy for required consent, next steps and training							
Budget							
Establish use of funds tracking for pilot within current system - IDN						Complete	
*Address unique DGR project code for salaries and expenditures							

Deliverable/Milestone	PRE-Q1	Q1	Q2	Q3	Q4		
Create funding matrix to show IDN funded areas and other supported positions, activities						Complete	
Establish use of funds tracking and budget table						Complete	
Share quarterly with IDN						Complete	
Key Organizational and Provider Participants							
Share formal award notice to all partners and supporting organizations						Complete	
Document and continually support referral partnerships						Complete	
Address any gap areas in partner support network- target through new partner cultivation						Complete	
Address cultural barriers and look to supported IDN trainings on culture change						Complete	
Network Development							
Project team review and identification of all formal project partners and community supports						Complete	
Assign team members to support development and outreach						Complete	
Continue to expand and develop the network of collaborating organizations						Ongoing	The project team will continue to refine and expand the partner lists as needed to support the patient
Review current process for developing new partner relationships						Ongoing	
Privacy & Security							
Train Staff on Treatment of Sensitive Patient Information						Underway	Ongoing Training
Execute Data Sharing Arrangement with Support Services Organizations							
*Identify areas where updates or new development is needed							
Linkage to IDN resources and forms						Complete	Continuous support to guide SCP usage in CMT and data sharing across MDCT
HIT Implementation							
Deploy Shared Care Plan Application						Complete	
Deploy Direct Secure Messaging Application						Complete	
Deploy Event Notification Application						Complete	
Deploy Clinical Quality Measurement Application						Complete	
HIT Components Completed and Functional						Complete	
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup						Ongoing	
Integration Assessment							
Complete SSA at 6, 12, 18 month intervals						Ongoing	Both SSA Deployments

Deliverable/Milestone	PRE-Q1	Q1	Q2	Q3	Q4		
Complete SSA at 6, 12, 18 month intervals						Ongoing	Both SSA Deployments have been captured by the team
Projet team coordination for SSA completion, submission, and review						Ongoing	
Evaluation							
Review for inclusion of evidence based practices determined in implementation plan						Ongoing	Given very early stages of the project deployment there is not yet a cohort for evaluation but initial data measures and processes for data capture are being formalized
At 6 month intervals (12/31/17, 6/30/18, 12/31/18) measure						Ongoing	
# of external community support referrals from B1 team						Ongoing	
Progress towards coordinated care practice designation						Ongoing	
Data Sharing							
Outcome data accumulated and reviewed						N/A	Due to Project Stage
Approve and disseminate data sharing forms to all project partners						N/A	Due to Project Stage
Share SSA Integration levels with B1 provider cohort						N/A	Due to Project Stage
*Support IDN efforts for data transparency through reporting and project outcomes presentation							
Meetings and Reports							
Documented minimum requirement met quarterly						Complete	
Knowledge Exchanges and IDN Involvement							
Share key learnings with IDN1 partners and participation quarterly						Complete	
Use of Funds							
Appropriate use of project funds used monthly and actuals reported quarterly						Complete	
Accountability of Time							
Accountability for use of staff time to serve project functions reported quarterly						Complete	
Project Defined Milestones							
Milestone: Q1						Complete	
Develop work group for project implementation							
Milestone: Q2						Complete	
Hire for position(s)							

Deliverable/Milestone	PRE-Q1	Q1	Q2	Q3	Q4	
Hire for position(s)						
Milestone: Q2, Q3						Complete
Adapt clinic work flow and processes for implementation						
Milestone: Q2						Complete
Develop Partnership Agreement with counseling service provider						
Milestone: Q2, Q3						Complete
Develop Standardized Workflows and Protocols						
Milestone: Q2, Q3						Complete
Create protocols to ensure safe care transitions from institutional settings						
Milestone: Q3						Ongoing
Implement Shared Care Plan						
Milestone: Q3						Ongoing
Implement Standardized Workflows and Protocols						
Milestone: Q4						Ongoing
Implement process for follow up after ED visit or hospitalization						
Milestone: Q4						Ongoing
Screening implemented across PCP office						
Milestone: Q4						Ongoing
Implement protocols to ensure safe care transitions from institutional settings						
Milestone: Q4						Ongoing
Comprehensive and consistent use of standardized core assessment framework						

Appendix C-1

Deliverable/Milestone	Task Assignments		Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
	Lead	Support	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
Implementation Year 1									
Recruit to Hire Coordinator Staff - M1, 2									
Finalize job description- Review by all team members and facilitators									Complete
Address hiring process with MFS, MC									Complete
*Outline timeline for internal hiring processes and projected date to hire									
Assign team support for job posting, resume review, and interview scheduling									Complete
Identify interview panel members									Complete
*Address tie-ins to workforce loan repayment planning									
Formalize E5 Coordinator Training plan (onboarding process and length)							10/24/2017	3/1/2018	Staff trained - existing training plan to be re-evaluated at next team meeting
*Include PHI Privacy and 42 CFR Pt. II needs									
Revise timeline process for date of hire to direct patient support							10/24/2017	12/1/2017	Complete - update with start of patient support
Project Team Development- M2									
Email to all partners notifying of project award							10/24/2017	11/9/2017	Complete
Schedule and plan for all-partner meeting							11/9/2017	12/1/2017	
Review partner roles : any need for additional support on project team	Phil	Kate C					11/9/2017	11/9/2017	Complete - external partners identified and are coordinated with by Co-Pilot Staff
Review community service organization partners and address any gaps	Phil	Maryanne					11/9/2017	11/9/2017	Kate C - send to Maryanne and Phil and ask for review
*Opportunity to address current referral and assessment gaps, high functioning processes, and technology capacity of partner entities									
									Current bi-weekly meetings held between Co-Pilot

Schedule recurring partner meetings (quarterly or semi-annual)									Current bi-weekly meetings held between Co-Pilot Staff.
Environmental scan for overlap with other Cheshire County projects, networks and coordinated meetings									Kate C to discuss with Phil and Maryanne
* IDN requirements will be met with leveraging existing structures									
Patient Identification and Screening - M2									
Identify priority data fields for screening	Phil / Team	Mark B							Complete; Co-Pilot staff tracking approved data fields in Co-Pilot Spreadsheet
Coordinate with B1 Planning Team at CMC (E5 Overlap)	Phil	Maryanne							Ongoing
Support IT and IDN HIT meeting for review of process steps and registry identification	Phil / Team	Kate							
Define target pilot caseload (size and acuity) for E5 Coordinators									Complete; see process map
Outline patient and reporting data collection needs - M2									
*Highlight current fields being met and new areas									
Develop rolling identification process for new client identification-M2, 3									
*Formalize and share with partners- support with referral process									
Target project team subgroup to address data and reporting									Group identified and will convene on 8/3.
Coordinate with HIT B1 implementation									
Address Shared Care Plan usage									in holding pattern while Cheshire Med Center onboards new IT system
*Leverage adoption and training support from other initiatives									
Screening and Assessment Tool Development -M2									
Review of current tools across partner network									Tools recorded and reviewed at strategic planning meetings. BAAs allowed for Co-Pilot staff to access tools across partnerships and organizations
Review of CTI case management toolkit									Update with info from the Co-Pilot staff / team meetings

Map end-to-end processes for CTI tailored to Cheshire sub-region									
Identify patient assessment protocols and tools									Referral form being piloted with referral sources;
Identify patient management protocols									
Identify referral process and tools									Referral form developed
Referral and Assessment process development- M2									
Outcomes Measurement - M									
Review pledged project outcomes with all partners									Ongoing - next review will be on 8/3 during sustainability / data planning meeting
Schedule quarterly project outcome review								8/30/2018	TBD - target for sustainability planning meeting
Schedule quarterly report targets and deadlines								8/30/2018	TBD - target for sustainability planning meeting
Analyze and review 6 months of project outcomes - M4									
Review and assess potential supplemental funding opportunities - M4									
*Focus on project sustainability									
Identify measures, targets for ongoing evaluation									
Develop tollgates to ensure adherence to CTI model for Phase I, II, III									
Formalize Internal Project Evaluation Process - M2									
Quarterly Performance Metrics Review by Oversight Team-Recurring - M									
Implement Measurements Project Dashboard - M3									
Training-M									
CTC participation in November 2017 CTI Training									Co-Pilot staff attended Nov. 15, 16th CTI training
CTC Supervisor participation in November and December CTI Training									Co-Pilot staff and team leader attended December 14th supervisor training
Participation in Summer 2018, CTI Train the Trainer sessions									
Develop and formalize E5 Coordinator training									
* Share with other project teams									
Legal and Privacy									
Assess current MFS, MC processes and forms									
Coordinate with B1 Planning Team at CMC (MFS Pilot)									

Execute data sharing agreements with partners, MOUs - M									
Budget									
Establish use of funds tracking and budget table									Establish protocol - Phil and Maryanne to provide update
Share quarterly with IDN									
Network Development									
Continue to expand and develop the network of collaborating organizations									Co-Pilot staff outreach update here
Identify Participating Support Services Organizations									
Formalize Relationship with Support Services Organizations									Jen Howard coordinating with Keene Housing
Build Awareness of new Resources Among Hospital Key Personnel									Jen S. coordinating with Tiffany to message to
CTI CTC's participation in Monthly Community of Practice meetings - M									
HIT Implementation- M2, 3									
Deploy Shared Care Plan Application									
Deploy Direct Secure Messaging Application									
Deploy Event Notification Application									
Deploy Clinical Quality Measurement Application									
Utilize technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup									
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup									Pending team readiness for deployment
Meetings and Reports									
Documented minimum requirement met quarterly									
Knowledge Exchanges and IDN Involvement									
Share key learnings with IDN1 partners and participation quarterly									
Use of Funds									
Appropriate use of project funds used monthly and actuals reported quarterly									
Accountability of Time									
Accountability for use of staff time to serve project functions reported quarterly									

Appendix D-1

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
Implementation Year 1	10/1/17-12/31/17	1/1/18-3/31/18	4/1/18-6/30/18				
Charter Completion- Final review and approval by all project team members					Q1	Q2	Complete
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month							
Team Meetings							
Set up recurring bi-weekly meetings to be attended by all applicable project team members at each meeting					Q1	Q2	Complete
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps					Q1	Q2	Complete
Recruit to Hire - M1, 2							
Document weekly progress toward position hiring and share with broader project team membership					Q1	Q3	Complete
Share job descriptions and links to postings with all project team members					Q1	Q3	Complete
Assign team member lead support for communication of progress and interview panel updates					Q1	Q3	Complete
Onboarding and Training							
role					Q1	Q3	Complete
*Share with all project team members and address willingness to share with other programs							
Create a training plan by needed position to share and replicate for subsequent hires					Q1	Q3	Complete
*Address privacy and consent training for role within IDN SCP							
Creation of staffing schedule					Q2	Y2 Q1	Draft complete, improvement planning indicating updating staffing needs to best address pt population efficiently and with best quality
Process Milestones and Reporting							
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM					Q1	Q4	Complete
Finalize operational dashboard for measures and measure collection					Q1	Q3	Complete
Present to larger project team for approval and finalization					Q1	Q3	Complete
Address IDN required data reporting and document reporting ownership with the project team. Identify lead and support for data and process reporting to					Q1	Q4	
Continuously collect and interpret outcome data- M3							
Outcomes Measurement							
Review pledged project outcomes with all partners					Q2	Q3	Complete
Schedule quarterly project outcome review					Q2	Q3	Complete
Schedule quarterly report targets and deadlines					Q2	Q3	Complete
							Program went live in Y1 Q4, will be assessed at 6 month

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
Analyze and review 6 months of project outcomes -M4					Q2	Y2 Q2	Program went live in Y1 Q4, will be assessed at 6 month mark
Review and assess potential supplemental funding opportunities -M4					Q2	Y2 Q1	This has been ongoing as new opportunities arise.
*Focus on project sustainability							
Training							
Develop and offer CBT training for applicable project staff					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Develop and offer DBT training for applicable project staff					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Develop and offer Motivational Interviewing/Enhancement training for applicable project staff					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Develop and offer Relapse prevention for applicable project staff					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Offer Circle of Security training for IOP staff					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Determine prioritized training guide and align with project timeline (address topics above and below)					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Offer Specific Trainings to Staff					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Prenatal care					Q2	Yr 2 Q2	improvement for staff needs
SUD-specific prenatal education:					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous
Risks of substance exposure, inclusive of tobacco/marijuana					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous
Managing pregnancy-associated side effects of MAT (primarily nausea and constipation)					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Optimizing nutrition during pregnancy and breastfeeding					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Neonatal abstinence syndrome: diagnosis, management, aftercare					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Pregnancy, HCV and/or HIV testing					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Breastfeeding and MAT					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Hospital drug testing policies					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Mandated reporting and the Plan of Safe Care					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
<i>Not pregnancy-focused</i>					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Screening and treatment for sexually transmitted disease, including partner treatment					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
Safe sex counseling, including condom distribution					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Cervical cancer screening					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Hepatitis and HIV education, screening, and referral					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Pregnancy testing, options counselling, and access to abortion care (referrals)					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Tuberculosis testing					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Counselling for pregnancy intention					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Influenza vaccination					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Domestic violence screening					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Tobacco use counselling and treatment					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Reproductive health education					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Curriculum development for pregnant and parenting women					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Case management training					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Psychiatric Assessment - Protocol development					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
MAT development					Q2	Yr 2 Q2	Ongoing training, completed for hired staff, continuous improvement for staff needs
Address training funding capacity through current project funding, current systems to leverage and opportunities for alignment with the IDN1 workforce priority areas							
Assessment and Materials Developed							
Document intake protocols					Q1	Q2	Complete
Document participation guidelines					Q1	Q2	Complete
Develop family support childcare guidelines					Q1	Q2	Complete
OP Initial curriculum development - M2					Q1	Q2	Complete
Formalize with project team support and roll up into program operations					Q1	Q3	Complete
Implement 6 month tollgates for materials review (curriculum, protocols etc.) - M3					Q1	Q3	Complete
Finalized Curriculum- M4					Q2	Q4	Complete

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
Budget							
Establish use of funds tracking for pilot and within current system					Q2	Q4	Complete
*Address unique DGR project code for salaries and expenditures							
Create funding matrix to show IDN funded areas and other supported positions, activities					Q2	Q4	Complete
Ongoing review of sustainable funding sources- M4					Q2	Yr 2	This has been ongoing as new opportunities arise.
Establish use of funds tracking and budget table					Q2	Q4	complete
Share quarterly with IDN					Q2	Q4	complete
Key Organizational and Provider Participants							
Share formal award notice to all partners and supporting organizations					Q2	Q2	
Document and continually support referral partnerships					Q2	Yr 2	Program has improved and onboarded new relationships. Continuing to work strengthen partnerships and finding new ways to develop more forman collaborations
Address any gap areas in partner support network- target through new partner cultivation					Q2	Yr 2	Program has improved and onboarded new relationships. Continuing to work strengthen partnerships and finding new ways to develop more forman collaborations
Patient Advisory Board- Determine meeting frequency, membership- M2					Q2	Q3	Complete
Network Development - M2, M3							
Develop outreach and program marketing campaign					Q2	Q4	Complete
Assign team members to support development and outreach					Q2	Q4	Complete
Continue to expand and develop the network of collaborating organizations					Q2	Q4	Complete
Review current process for developing new partner relationships and					Q2	Q4	Complete
Assessment and Screening Tools							
Develop with Project Team Scope of Work assessment and screening minimum requirements					Q2	Q4	Complete
Utilize a comprehensive core assessment and a care plan for each enrolled patient, updating regularly					Q2	Q4	Complete
Coordinatse with the B1 projects for SCP and CCSA Analysis					Q3	Yr 2 Q2	Team working with organizations B1 project
Determine screening used for client triage and caseload assignment					Q3	Q3	Complete
Institute continous improvement and review of the referral process functionality					Q2	Yr 2 Q2	Team is continuously improving community relationships and referral process to program
Set up Referral to Recovery Supports process					Q2	Q4	complete
Set up Referral to Counseling process					Q2	Q4	complete
Set up Inbound Referral process					Q2	Q4	complete
Privacy & Security							
Train Staff on Treatment of Sensitive Patient Information							complete
Execute Data Sharing Arrangement with Support Services Organizations -M2							complete
Review current PATP consent and privacy forms							complete

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
*Identify areas where updates or new development is needed							
Assess current VRH processes and forms							complete
Coordinate with B1 Planning Team at VRH							complete
Linkage to IDN resources and forms							complete
Execute data sharing agreements with partners -M							complete
HIT Implementation							
Deploy Shared Care Plan Application							Pending Team Readiness and Coordination with B1
Deploy Direct Secure Messaging Application							Pending Team Readiness and Coordination with B1
Deploy Event Notification Application							Pending Team Readiness and Coordination with B1
Deploy Clinical Quality Measurement Application							Pending Team Readiness and Coordination with B1
HIT Components Completed and Functional - M2, M3							
Utilize technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup							
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data							
Launch Services- M2, M3							
Create timeline for program expansion rollout from Monday to Thursday clinical implementation					Q2	Q3	Complete
Identify population of Medicaid-eligible women with substance use disorders who meet criteria for ASAM level 2.7 services					Q2	Q3	Complete
Implement evidence-based, trauma-focused curriculum					Q2	Q3	Complete
Implement co-location model					Q2	Q3	Complete
Provide Comprehensive Screening/Intake Assessment					Q2	Q3	Complete
Provide Care Planning including addressing all ASAM domains, medical, and psychiatric needs					Q2	Q3	Complete
Operate 8-week IOP Treatment Model to include the following:					Q2	Q4	Complete
Provide Referrals to Counseling					Q2	Q4	Complete
Provide Referrals to Peer Supports/Recovery Coaches					Q2	Q4	Complete
Provide Referral to Smoking Cessation Support					Q2	Q4	Complete
Receive Inbound Referrals					Q2	Q4	Complete
Provide Life Skills Programming					Q2	Q4	Complete
Provide Urine drug screens and breathalyzer testing					Q2	Q4	Complete
Provide continuing services post 8-week IOP					Q2	Q4	Complete
Expand Childcare Model- M2, 3							
Expand current childcare model					Q2	Q3	Complete
Provide childcare during group sessions					Q2	Q3	Complete
Address formalizing priority criteria for supporting participants with					Q2	Q3	Complete
Business Case							
Develop initial Business Case for Scaling the IOP model					Q4	Yr 2 Q3	Team is continuing to develop plan
Test and Refine Business Case for Scaling the IOP model					Q4	Yr 2 Q3	Team is continuing to develop plan

Deliverable/Milestone	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
Business Case							
Develop initial Business Case for Scaling the IOP model					Q4	Yr 2 Q3	Team is continuing to develop plan
Test and Refine Business Case for Scaling the IOP model					Q4	Yr 2 Q3	Team is continuing to develop plan
Evaluation							
Establish 2018/2019 program objectives -M4					Q4	Q4	Complete
Data Sharing							
Address data sharing with PATP, IDN					Q2	Q4	Complete
Outcome data accumulated and reviewed					Q2	Q4	Complete
Approve and disseminate data sharing forms to all project partners							
Support IDN efforts for data transparency through reporting and project outcomes presentation					Q2	Q4	Complete
Meetings and Reports							
Documented minimum requirement met quarterly					Q1	Q4	Complete
Knowledge Exchanges and IDN Involvement							
Share key learnings with IDN1 partners and participation quarterly					Q1	Q4	Complete
Use of Funds							
Appropriate use of project funds used monthly and actuals reported quarterly					Q1	Q4	Complete
Accountability of Time							
Accountability for use of staff time to serve project functions reported					Q1	Q4	Complete

Identification of Patient Registry - M2							
Identify priority data fields for screening							In progress - cases being piloted for discussion. Referral form drafted.
Define target pilot caseload (size and acuity)							group determined 1 - cases per meeting to be discussed, dependant on need
Outline patient and reporting data collection needs - M2							
*Highlight current fields being met and new areas							
Develop rolling identification process for new client identification							
*Formalize and share with partners- support with referral process							
Target project team subgroup to address data and reporting							
Coordinate with HIT B1 implementation							
Address Shared Care Plan usage with E5 team							
*Leverage adoption and training support from other initiatives							
Screening and Barriers Tool Development -M2							
Review of current tools across partner network							
Identify a tool development timeline for workgroup	JP	Kcox					Ongoing Will be developed after referral form and criteria are landed
Review and adopt screening barriers assessment with partner agencies- M2							Ongoing
Referral and Assessment process development- M2							Ongoing
Partner approval and adoption							Ongoing
Support training for all referral sources- M2							
Schedule partner referral process review at 3-6 months utilization -M2,3							
Outcomes Measurement							
Review pledged project outcomes with all partners							
Schedule quarterly project outcome review							
Schedule quarterly report targets and deadlines							
Analyze and review 6 months of project outcomes -M4							
Review and assess potential supplemental funding opportunities -M4							
*Focus on project sustainability							
Legal and Privacy							
Coordinate with B1 Planning Team at VRH							
Linkage to IDN resources and forms							
Execute data sharing agreements with partners -M							
Budget							

A	B	C	D	E	F	G	H	I	J
Budget									
Establish use of funds tracking and budget table									
Share quarterly with IDN									
Network Development									
Continue to expand and develop the network of collaborating organizations									
*Formalize all new partnerships through the "Coordinated Referral Partnership									
HIT Implementation									
Deploy Shared Care Plan Application									
Deploy Direct Secure Messaging Application									
Deploy Event Notification Application									
Deploy Clinical Quality Measurement Application									
Utilize technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup									
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup									
Meetings and Reports									
Documented minimum requirement met quarterly									
Knowledge Exchanges and IDN Involvement									
Share key learnings with IDN1 partners and participation quarterly									
Use of Funds									
Appropriate use of project funds used monthly and actuals reported quarterly									
Accountability of Time									
Accountability for use of staff time to serve project functions reported quarterly									