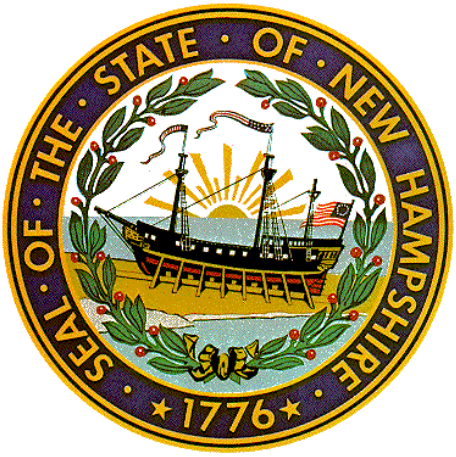


New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL REPORTING GUIDE

For

Year 4 (CY2019)

2020-01-31 v.28

Final

Region 1 IDN

Contents

Introduction **5**

DSRIP IDN Project Plan Implementation (PPI) 6

Project A1: Behavioral Health Workforce Capacity Development **5**

A1-3. IDN-level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan 5

Narrative 5

A1-4. IDN-level Workforce: Evaluation Project Targets (No change July-Dec, 2019) 9

A1-5. IDN-level Workforce: Staffing Targets 12

A1-5: Current Community Project Pilot Staffing **14**

A1-6. IDN-level Workforce: Building Capacity Budget 16

A1-7. IDN-level Workforce: Table of Key Organizational and Provider Participants 19

Project Scoring: IDN Workforce Process Milestones 22

A2-3. IDN HIT/HIE: Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan 23

A2-4. IDN HIT: Evaluation Project Targets 37

A2-5. IDN HIT: Workforce Staffing 37

A2-8. IDN HIT. Data Agreement 48

Project B1: Integrated Healthcare **50**

B1-2. IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan 50

B1-3. IDN Integrated Healthcare: Evaluation Project Targets 93

B1-4. IDN Integrated Healthcare: Workforce Staffing 95

B1-5: IDN1 Integrated Healthcare Budget 98

B1-6. IDN Integrated Healthcare: Key Organizational and Provider Participants 111

B1-7. IDN Integrated Healthcare: IDN Governance Leadership Sign-off 111

B1-8. Additional Documentation as Requested in B1-8a-8h 112

B1.8a CCSA Utilization 113

B1.8a Pediatric CCSA Utilization 143

B1.8b Multi-Disciplinary Care Team Members by Practice 144

B1-8c. Required Training 145

B1-8d. Non Direct Care Staff Training 146

B1-8e. Multi-Disciplinary Core Team Schedule 147

B1-8h. Documented Workflows and/or Protocols: 151

B1-9a. Report on progress toward coordinated care designation 167

B1-9b. MAT 168

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 **183**

C-1. IDN Community Project: Core Components, Process Milestones, Training and Evaluation Project Plans 183

C-2. IDN Community Project: Evaluation Project Targets 197

C-3. IDN Community Project: Workforce Staffing 200

C-4. IDN Community Project: Budget **200**

C-5. IDN Community Project: Key Organizational and Provider Participants 202

C-6. IDN Community Project: Standard Assessment Tools 202

C-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals 203

C-8. IDN Community Project: Member Roles and Responsibilities 204

C-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3 204

Project Scoring: IDN Community Project Process Milestones 206

D-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan 207

D-2. IDN Community Project: Evaluation Project Targets 221

D-3. IDN Community Project: Workforce Staffing 224

D-4. IDN Community Project: Budget 225

D-5. IDN Community Project: Key Organizational and Provider Participants 226

D-6. IDN Community Project: Standard Assessment Tools 227

D-8. IDN Community Project: Member Roles and Responsibilities *(No change January – June, 2019)* 229

D-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3 (*Updates July – December, 2019)* 230

E-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan ..... Error! Bookmark not defined.

E-2. IDN Community Project: Evaluation Project Targets ..... Error! Bookmark not defined.

E-4. IDN Community Project: Budget ..... Error! Bookmark not defined.

E-5. IDN Community Project: Key Organizational and Provider Participants ..... Error! Bookmark not defined.

E-6. IDN Community Project: Standard Assessment Tools ..... Error! Bookmark not defined.

E-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals ..... Error! Bookmark not defined.

E-8. IDN Community Project Member Roles and Responsibilities ..... Error! Bookmark not defined.

E-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3 Error! Bookmark not defined.

DHHS Project Scoring: IDN Community Project Process Milestones ..... Error! Bookmark not defined.

Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning **261**

DSRIP Outcome Measures for Years 4 and 5 ..... **262**

Appendix A1-3: 264

Appendix B1-2: DH-Heater Rd and WCBH 269

Appendix B1-2: VRH and CA 274

Appendix B1-2: CMC/MFS 275

Appendix B1-2: APD 279

Appendix B1-2: NHC 284

Appendix C-1 285

..... 287

Appendix D-1 289

Appendix E-1 295

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
January 1, 2019 – June 30, 2019	July 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)

Narrative

Provide a detailed narrative to reflect progress made during this reporting period as it relates to the Administration, Network, and Governance.

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

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	6/30/19
PPI	Project Plan Progress, including: Community Input, Network, Opioid Crisis Update, Governance, and Budget	Narrative and budget spreadsheet	Met	Met	Met	Met	Met

Soliciting Community Input:

(All updates by reporting period shared in bullet format)

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*
- Community Member input to Integration Design (Ongoing)
- Listening Tour (First Round in 2017, 2nd Round with B1 Partners in 2018 3rd round in 2019 with new IDN 1 partners),
    - *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
- IDN Administration have ongoing involvement in the Public Health Network meetings within the region.

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

During the period of July to December 2018, the Region 1 IDN team:

- Continued with community member, patient input and engagement at the project level where possible
- Attended several county/community events to discuss with providers/consumers the value of the global IDN program and the impact of the local projects/added resources
    - *Added CEO of community hospital in Sullivan County to Executive Committee for many reasons, including his relationship with the county administrator, commissioners and delegation*
- Conducted 3rd Round of Listening Tour:
    - *IDN 1 Executive Director met with partner leadership in fall 2018 to discuss priority areas for expanding workforce capacity and emerging/evolving resource needs.*
- Community Members in Governance Roles (Ongoing):
    - *Added one community member to our Executive Committee who is also the Executive Director of two of the peer support agencies in our region.*

During the period of January to June 2019, the Region 1 IDN team:

- *Expanded upon ongoing efforts of involvement at the project team levels as well as the regional level through Knowledge Exchanges, Advisory Council Meetings, Regional Data and IT Workgroup, Performance Leadership Discussions.*
- Continued with community member, patient input and engagement at the project level where possible
- *Continued to engage with County level discussion to promote the work of the IDN, provide clarification and to continue to build ongoing relationships.*

- *Continued to attend and engage in community and state events about topics associated with IDN goals such as workforce.*
- *Engage with partners outside of the region to include statewide perspectives and trends affecting region 1 climate.*
- *Continued recruitment and retention activities to ensure partner organization representation across Executive Committee members*

During the period of July to December 2019, the Region 1 IDN team:

- *Expanded upon ongoing efforts of involvement at the project team levels as well as the regional level through Knowledge Exchanges, Advisory Council Meetings, Regional Data and IT Workgroup, Performance Leadership Discussions.*
- *Continued with community member, patient input and engagement at the project level where possible*
- *Continued to engage with County level discussion to promote the work of the IDN, provide clarification and to continue to build ongoing relationships.*
- *Continued to attend and engage in community and state events about topics associated with IDN goals such as workforce.*
- *Engage with partners outside of the region to include statewide perspectives and trends affecting region 1 climate.*
- *Continued recruitment and retention activities to ensure partner organization representation across Executive Committee members*
- *Continued participation in the Regional Public Health Network meetings across the IDN1 catchment area*
- *Participation in community forums regarding both funded and non-funded IDN efforts in the IDN1 catchment counties*

Network Development:

(All updates by reporting 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, 2019

- Given the point in project implementation the IDN is not onboarding many new partners. The IDN is always open to new partner engagement and assessing an organizations fit to join the IDN

network. This process has been formalized by the IDN executive committee and includes questions for any new onboarding organizations and identifies if the service provided fills a current IDN gap area. This identification and vetting also weighs the organizations Medicaid penetration.

- In CY2019 the IDN has expanded conversations with the Dept. of Corrections in Sullivan County to address continued support of the expansion of the E5 project work.

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, 2019

- The IDN team continued to refine the Integrated Care Team pool of organizations and providers throughout 2019 in an effort to concentrate support and financial incentive to those organizations with the most significant population.
- By the end of summer, 2019 the IDN1 team had concluded this process and resigned contracts with all B1 partners to run from 7/1/19- 12/31/20.

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, 2019

- In the past reporting period, no new partner projects were on boarded. Expansions continued with existing projects.
- The IDN administrative team released a July 2019 Workforce RFA to support the following:
    - Recruitment & Retention, Loan Repayment, Supervision and Internship Capacity

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

Updates for Semi Annual Period: July-December, 2019

- IDN 1 in CY2019 restructured the contracting process to decrease administrative burden on the administration team as well as to ensure secured funding to project teams through the end of the DSRIP waiver. Each team will be awarded on a sixth month bases core funding in accordance to their quarterly achievements and adherence. Additional awarded dollars based on performance will be awarded to teams based on a Medicaid attribution algorithm. This will ensure sustainability for the teams to build on their current project work, while incentivizing them to support achievement in the performance period. These contracts became effective 7/1/19 and the first semi-annual review term was underway at the time of writing.

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, 2019 (No change)

- IDN1 continues to incentivize community support partners across the project portfolio to support the B1 projects in downstream capacity to address positive SDoH screens across the patient population.
- Additionally, IDN1 has worked with Phoenix House, Headrest, and Pathways so expand their capacity for support and directly like their services to B1 work.
    - Headrest is playing an active role in the MDCT meetings as applicable at DH HRS/WCBH

Addressing the Opioid Crisis (No change in efforts during July-December, 2019)

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.

IDN-1 has been involved in the ongoing coordination efforts across IDN providers to align various funding and projects addressing the opioid crisis. Some ongoing efforts with 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 met with the APD team continuously throughout the planning of the MAT program. The team has fully implemented the program and the IDN Medical Director continues to support their ongoing efforts.
    - 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 and programs such as the work through the Substance Use and Mental Health Initiative (SUMHI) and the Opioid Addiction Treatment Collaborative Project Work. Additionally, IDN 1 Administration continues to align effort with the states Doorway work, where DHMC - Lebanon is a hub.
    - 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. Additionally, IDN 1 Administration continues to align effort with the states Doorway work, where CMC is a hub.

- Cheshire Medical Center received a 3-year, $900K 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 continues to support 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. With the work of the Doorways program now underway, IDN 1 administration continues to have conversations with project leads and partners involved to align efforts and promote better patient access and care.

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.

IDN 1 Administration:

In July-December, 2019 the IDN1 Administration team had no changes.

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.

Updates for Semi Annual Period: July-December, 2018

- Expanded EC membership has grown to include Susan Seidler for Next Step, C. Tyler Vogt, MD of DH Heater Road and Peter Wright of VRH

Updates for Semi Annual Period: January – June, 2019

- The IDN1 EC experienced some changes in the semi-annual period including:
    - The departure of Peter Wright, former CEO of VRH
        - Charlene Lovett, Mayor of Claremont was brought on board to fill his seat representing Sullivan County
    - The departure of Lindsay Lafontaine, Patient/Family Member
        - This seat is still under recruitment
    - The onboarding of Peter Starkey, Executive Director of Monadnock Peer Support Agency
    - The pending departure and retirement of Suellen Griffin, Executive Director of West Central Behavioral Health
        - Ongoing recruitment for a replacement member to fill this seat continues

Updates for Semi Annual Period: July- December, 2019

- *There were no significant changes to the Executive Committee membership in the semi-annual 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, 2019

- The IDN1 team held one Advisory Council meeting in October, 2019 at the Common Man in Claremont. See below for agenda:

DSRIP 1115 Waiver
IDN Region #1: *Partnership for Integrated Care*
October 10, 2019
Fall Advisory Council Meeting: Sustaining the Value

Time	Topic	Leader
8:00 – 8:55	Networking Coffee & Breakfast Buffet *Project Update Slides and Materials Presented	-
9:00 – 9:15	Welcome & Opening Remarks	Dennis Calcutt, Chair, Region 1 IDN Executive Committee & Jessica Leandri Region 1 Executive Director,
9:15 – 9:30	Patient Impact Stories	Alice Peck Day Integrated Healthcare Project Team
9:30 – 10:00	Performance-Based Funding & Data Updates	Mark Belanger, Region 1 Director of Integration
10:00 – 10:45	Remaining 16 Months: What's next for IDN1	Facilitated by Peter Mason, Region 1 Medical Director
10:45 – 11:00	Break	-
11:00 – 11:45	Sustaining the Value	Facilitated by Peter Mason, Region 1 Medical Director
11:45 – 12:00	Closing and Session Evaluation	Dennis Calcutt, Chair, Region 1 IDN Executive Committee & Jessica Leandri Region 1 Executive Director

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: July-December, 2018

- The finance committee continued to meet through July-December, 2018 with mixed attendance.
- Lynn Guillette, the VP of Payment Innovation at DH and Chair of the Finance Committee did host an APM focused lunch and learn session in fall, 2018.

Updates for Semi Annual Period: January-June, 2019

- The finance committee met during the semi-annual period and many members of the IDN1 committee attended several payment focused training and conferences throughout the term.

Updates for Semi Annual Period: July-December, 2019

- *The finance committee continued during the semi-annual period and many members of the IDN1 committee attended several payment focused training and conferences throughout the term.*

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: January – June, 2019

- The IDN1 Data & IT workgroup continued to meet and make progress on team targets throughout the first half of 2019.
- The group is sharing data and consistently reviewing as transparently as possible.
- The workgroup continues to review and support the IDN1 overarching data and IT rollout
- Focus of this group has shifted to center around pay for performance and supporting ongoing communication to partners on this process

Updates for Semi Annual Period: July-December, 2019

- *The IDN1 Data & IT workgroup continued to meet and make progress on team targets throughout the second half of 2019.*
- *The workgroup is sharing all data transparently and identified by organization.*
- *The workgroup continues to review and support the IDN1 overarching data and IT rollout*
- *Focus of this group has shifted to center around pay for performance and supporting ongoing communication to partners on this process*

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 across the project areas and statewide initiatives. Region 1 has remained conservative with its spending during this planning period. Due to the funding uncertainties first identified in December of 2017 and have continued throughout this reporting period, the Region 1 IDN Executive Committee voted to withhold expansion of the Community Projects and 50% of the Workforce Funds in order to commit full funding for current B1 and Community Projects as well as the required HIT infrastructure costs.

The budget below reflect expenses for last six months (7/1/19 – 12/31/19). Once the funding uncertainties are resolved at the state level, IDN 1 will revise its budget to reflect any reduction in funding, approved revisions to the implementation plan (based on funding changes) and an increased contingency to reflect potential uncertainty.

See below for a budget reflecting projected expenditures across projects through CY2021- this budget has been constructed to include all known components of IDN operations and projects to date by CY but is subject to change:

Description	Actuals CY 2016	Actuals CY 2017	Actuals CY 2018	Actuals Jan-Jun 2019	Actuals Jul-Dec 2019	Projected 2020	Projected 2021	Total
Revenue (Received)	2,816,620	2,801,209	1,520,307	2,271,947	-	3,820,762		13,230,845
								-
Direct Expenses								-
Behavioral Health Needs Assessment	10,000	33,052						43,052
Development of IDN Project Plan	-	51,317						51,317
Statewide Project: Capacity Building (A1)	-	14,500	328,086	378,171	535,484	400,000		1,656,241
Statewide Project: Health IT (A2)	56,445	452,380	860,913	144,403	128,314	221,096		1,863,552
Core Competency: Integrated Healthcare (B1)	-	45,319	286,230	353,538	770,633	3,328,507		4,784,226
Community Projects	-	132,067	342,077	106,606	632,693	1,265,387		2,478,830
IDN Administration/Management	32,652	355,104	518,724	315,401	284,489	456,248	86,624	2,049,243
								-
Total Direct Expenses	**99,097**	**1,083,738**	**2,336,031**	**1,298,120**	**2,351,613**	**5,671,238**	**86,624**	**12,926,460**
								-
Indirect Expenses 15%	14,865	162,561	350,405	194,718	352,742	850,686	12,994	1,938,969
								-
Total	**113,962**	**1,246,299**	**2,686,435**	**1,492,837**	**2,704,355**	**6,521,923**	**99,618**	**14,865,429**

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: January – June, 2019

- IDN1 continues work with all of the contract HIT vendors and MaeHC continues to support regional partners in there quality reporting as well as vender implementation.

Updates for Semi Annual Period: July-December, 2019

- IDN1 continues work with all of the contract HIT vendors and MaeHC continues to support regional partners in there quality reporting as well as vender implementation.
- During SAR writing the IDN1 team was notified to changes with HIT vendor regarding Quality Data aggregation and will report further in the upcoming submission.

Integration Assessment: A contract was supported by the Region 1 Executive Committee to subcontract with the NH Citizens Health Initiative to provide a tool for integration assessment across the B1 providers. The term of funding will cover two 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 for B1 practices new to implementation. See B1 Implementation Plan section for additional details.

Updates for Semi Annual Period: January – June, 2019

- IDN1 launched the 3rd round of the SSAs across the B1 partner pool in late November, 2018 and the IDN completed the round in late January, 2019
    - A roll up report debrief with UNH was held in late February
    - Following the report out, IDN admin presented the information to the Region during a scheduled Knowledge Exchange in March, 2019 and individual assessments were reviewed and discussed during team meetings.
    - The next round of assessments are schedule to start in early August, 2019
- IDN1 is committed to SSA's at minimum annually for the duration of the waiver implementation but given significant barriers to project completion may look at the feasibility of reducing frequency from every 6 mos.

Updates for Semi Annual Period: July- December, 2019

- *The IDN1 teams in partnership with UNH CHI completed the 18month SSA results and review in fall, 2019.*
- *The next round of SSA assessment is set to launch in March, 2020.*

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.

Updates for Semi Annual Period: January – June, 2019

- IDN1 continues to support trainings and offer funded slots at hosted trainings across the state- see details in section A1 on trainings.

Updates for Semi Annual Period: July-December, 2019 (No change)

- *IDN1 continues to support trainings and offer funded slots at hosted trainings across the state- see details in section A1 on trainings.*

Project A1: Behavioral Health Workforce Capacity Development

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

Narrative

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 to reflect progress made toward recruitment, retention, hiring and training during this reporting period.

The Region 1 team continued to focus its regional workforce efforts during this reporting period on securing and retaining staffing levels for the eleven projects and providing necessary training to IDN1 partners. At this stage in implementation the IDN1 projects are fully staffed and efforts have toggled to retention support and sustainability planning for post DSRIP funding.

IDN1 released three rounds of Workforce funding RFA's in CY2019. The first application round commenced in late 2018 and wrapped up in late February, 2019. One RFA round was released during the reporting term of late spring, early summer 2019 in the areas of Recruitment & Retention, Internship and Supervision Capacity.

IDN 1 shifted to an incentive-based contract approach to B1 support organizations which enables these organizations to hire additional resources as needed to meet the requirements of the projects. This incentive based funding was incorporated in all active project contracts as of 7/1/19.

As in previous years beyond providing direct funding to projects, IDN 1 continued to think creatively on how to support partners' strategies to expand workforce capacity. This capacity includes organizations' abilities to not only bolster recruitment and retention efforts but also to facilitate closed loop referrals and address the social determinants of health needs of the Medicaid beneficiaries. Much of this continued effort was directed in the subcategories included for RFA funding in winter, 2019 and in the June/July, 2019 release. These funds are designed for 12 month use. With the close of the summer, 2019 award period it concluded a 20 month push by the Region 1 team to support our partners across the network in expanding their capacity around workforce. Many partners have expressed the value of these awards and through feedback to the administrative team have continued to inform the categories selected for funding in each RFA cycle.

With the support the IDN1 Executive Committee despite continued funding uncertainty the administrative team was able to offer the release of the remaining 50% of unallocated workforce dollars in the June/July 2019 RFA. The summer, 2019 RFA released $644,151 to 11 IDN1 partner organizations.

			Entry Level &Retention Support									
		Loan Repayment 13 @ 10,000	Sign on Bonuses - 11@$5000	Staff Referral Bonuses 5@$3000	Relocation Reimbursement 6@$5000	HR Recruitment Strategy - 5@$4000	Retention Bonus/Strategy 13@$10,000	Supervision Capacity Support 3@$20,000, 7@$10,000	Internship Stipend Support - 7@$15,000	Org Capacity Support for Interns - 7@$5000	Indirect (Max 10%)	*TOTALs*
Organization	**Total Avail**	**$130,000**	**$55,000**	**$15,000**	**$30,000**	**$20,000**	**$130,000**	**$130,000**	**$105,000**	**$35,000**		***$650,000***
Totals		$ 135,000	$ 79,250	$ 5,000	$ 10,000	$ 13,190	$ 147,650	$ 106,000	$ 81,000	$ 32,561	$ 11,500	***$ 644,151***
Total Avail - Total Requested		*$ 5,000*	*$ 24,250*	$ (10,000)	$ (20,000)	*$ (6,810)*	*$ 17,650*	$ (24,000)	$ (24,000)	$ (2,439)		*$5,849*

These RFAs have continued to increase partner engagement across the IDN, especially with partners who had previously been less involved in set projects. The RFAs have also facilitated additional collaboration in IDN 1 sub-regions as the community stakeholders, including county administrators and educators, have met to decide how the community could best leverage the funds offered in a RFA.

Region 1 continued during this reporting period to support all Statewide Workforce Taskforce activities, currently serving on all four sub-committees 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. 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 has 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
- New Hampshire Behavioral Health Summit

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. Region 1 IDN continues to play an active role where possible in statewide conferences, trainings and in supporting coordinated efforts to bring resources to our partners.

The Region 1 Medical Director supported the work and dissemination of the Addiction 101/MAT "Roadshow" presentation. At Alice Peck Day Memorial Hospital, the model site for overcoming barriers to expanding MAT in primary care, all of the providers in the Multi-Specialty Clinic are now waivered and providing MAT, a robust counseling program, including warm hand-offs and team co-ordination, has

begun in collaboration with Headrest and the program has been presented both regionally in New England and nationally. The IDN1 Medical director has supported several partner projects with MAT presentations throughout the semi-annual term. Additionally, IDN 1 has been collaborating with all of the IDNs in engaging with the AHECs to meet the collective statewide goals.

During this last calendar year, Region 1 IDN shifted the use of the monthly Knowledge Exchange sessions to alternate bi-monthly for all IDN partners and B1 partners. This divided scheduling has allowed the IDN team to garner stronger attendance in each session and refocus on the highest need areas for project partners and involved network organizations.

The IDN has led sessions focusing on the coordination of the Care Team Coordinator roles within B1 Projects, Review of the ASAM Criteria and will continue to draw from needs presented by the B1 teams for the limited partner sessions, Care Coordination and some organization spotlights such as on the programs in operation with partners like Southwestern Community Services that serve many IDN1 communities. For the full network sessions the team plans to continue to offer trainings as available and begin to spotlight some partner organizations with expanded provider capacity.

Region 1 IDN ultimately sponsored or sent partners to the following trainings from July to December, 2019:

Training	Month	Required	# of People Trained	# of Participating Partner Orgs	Audio/Materials Available on Website	Financially Sponsored/ Supported by IDN 1
Cherokee Health Systems	Jun	N	27	15	N	Y
Mental Health First Aid	Sept, Nov	Y	45	21	N	Y
Pathways Community HUB	Nov	N	NA	NA	NA	Y
NH Behavioral Health Summit	Dec	N	30	17	N	Y

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 or the IDN 1 Advisory Council meetings. 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 continues to disseminate all required and optional trainings as well as resources on its website (http://region1idn.org/) and shares these trainings across all of the IDNs as requested. Wherever possible, IDN 1 posts both the audios and supporting materials.

Recruitment and Retention

IDN 1 partners have continued to share success stories from the previously issued Workforce RFA's. Many of the awardees have concluded their 2019 awards. Partners were able to secure hires with loan repayment options, sign-on bonuses and relocation reimbursements as well as strengthen supervision and internship programs. Additionally, one organization saw a decrease in attrition rate which the CEO partially credited to the workforce funds.

Based on this success, IDN 1 released the third phase of the Workforce Request for Funds in June, 2019 for $644,151 for through June, 2020. This iteration evolved based on direct feedback from IDN 1 partners after experiencing respective successes and challenges with the first RFA. As mentioned above, this version allocates additional funding for retention strategies and loan repayment options as well as around supervision and internship support.

The administrative team has also worked with key project team leadership to determine appropriate retention bonuses for IDN-funded positions instrumental to project success.

A1-4. IDN-level Workforce: Evaluation Project Targets (No change July-Dec, 2019)

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. Please see Attachment A1.3A for additional detail.

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	2 (+1 Recruit to Hire Underway)
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.	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. Given this shift the target has been reassigned for support of ongoing recruitment and retention efforts underway with IDN1 partners. This target has been MET.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	**As of 12/31/18**
Hits on the Website	Up to 100	0 hits on Region 1 IDN related to job search; Project positions were posted on specific organizatio n'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	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: Jul: 4297 Aug: 6575 Sep: 8171 Oct: 8210 Nov: 7723 Dec: 8102 Total Visits: Jul: 1380 Aug: 1708 Sep: 1992 Oct: 2539 Nov: 2377 Dec: 2247
Interviews with "Trailing Partners"	Up to 10	3	3: Still waiting on response from River Valley Human Resources Association to present at meeting	3: Still waiting on response from River Valley Human Resources Association to present at meeting; Developed communication plan/protocol to be shared with partners and external businesses
Applications for Loan Repayment	Up to 20	0	4	4 (this is for the State Loan Repayment program. We have supported multiple partner organizations in supporting multiple employees with Loan Repayment)
Culture Change/Integration education sessions	4	3	0	1

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.	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 recommended leveraging and supporting existing community forums to celebrate progress in mental health/SUD. Additionally, the group believed this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan. IDN 1 participated in sponsoring the NH Behavioral Health Summit in December which celebrated progress across the state in mental health/SUD care.
Educational institutions engaged in the workforce expansion project	3	3	3	3
Meetings with IDN's and AHECs on statewide strategies	2	3	5	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	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 of 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.

No change from July-December, 2018 submission: 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 two reporting periods. 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 continued to incorporate recruitment incentive dollars into each B1 Integrated Healthcare project-based position. Simultaneously, Region 1 IDN also used the Workforce Fund RFA Phase I from the first half of 2018 to address general gaps across our region for behavioral health workforce needs (many of these contracts continued to release funds through December of 2108), including MLADCs, psychiatrists and peer recovery coaches; Phase II of this workforce fund RFA was released at the end of December. 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. IDN 1 has executed one contract for peer recovery coaching to be implemented in 2019 and has a pending RFA with additional dollars to be allocated to this area.

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	Staffing on 6/30/19	Staffing on 12/31/19
Master Licensed Alcohol and Drug Counselors	Up to 8	0	0	*Workforce Funds contributed to the recruitment of 1 MLADC	*Workforce Funds contributed to the recruitment of 1 MLADC and 1 director of SUD	1	**1(B1)**
Behavioral Health Care Coordinators	Up to 6	0	5 (B1/C1/E5)	6	6 (Includes B1 CTC Hires)	6	**6 (B1)**

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	Staffing on 6/30/19	Staffing on 12/31/19
Psychiatrists	Up to 4	1 *Indicates shift in current staff time to support IDN project implementation	.3 (D3)	.3 (D3)	.3 (D3)	.5	**.4 (D3)**
Psychiatric APRN's	Up to 2	0	0	0	.20 FTE	.2	**.2 (WF Award)**
Clinical Psychologists/Neuropsychologists	Up to 4	0	0	0	While many partner organizations would be interested in this level of licensed BH position due to lack of availability and funding issues these positions are not being pursued in favor or lower level BH positions.	“”	**.25 (WF Award)**

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	Staffing on 6/30/19	Staffing on 12/31/19
Licensed Community Mental Health Counselors and/or Licensed Social Workers	Up to 6	1	1.5 (D3)	2.5 (D3, B1)	2.5 (D3, B1)	4.5	**4.5 (D3,B1)**
Peer Recovery Coaches	Up to 10	0	.5 (D3)	.5 (D3)	.5 (D3) 2.4 FTE (Offset through WF RFA)	.5 (D3)	**.5, Offset through WF (D3)**
AmeriCorps-Community Mental Health Workers	6	* Service Year begins in October, 2017	0	3	3	3	**3 (B1)**

A1-5: Current Community Project Pilot Staffing

- The B1 Projects are fully staffed with one outstanding position in recruit to hire within DH Pediatrics. Position hired and starting 4/6/2020.
    - **Please note for the B1 section has only been required in the A1-5 table since the January-June, 2019 submission thus there are no projections or historical staffing data for CY2017, 2018**
- **The D3: PATP – IOP team is staffed fully minus a .3FTE BH**
- The C1: Co-Pilot team is fully staffed as projected. **(Co-Pilot is a hybrid C1/E5 project and staffing is reflected in both sections of the table)**
- E5 Update: Due to the challenges shared in the last two semi-annual reports, IDN 1 restructured the E5 project to reside within the IDN for the short-term. IDN1 hired a Project Manager to run the program in December, 2019. **This project is fully staffed as current project plans indicate across all 3 E5 projects : Sullivan County Complex Care Team, Sullivan County HUB, and the Enhanced Care Coordination arm of the Co-Pilot project (C1/E5 hybrid**).

			Baseline	Staffing on		Staffing on 12/31/18	Staffing on 6/30/19	Staffing on

Project Code	Provider Type	Projected Total Need	Staffing on 6/30/17	12/31/17	Staffing on 6/30/18			12/31/19
B1	Care Team Coordinator						1FTE	2FTE
	BHC Licensed						2.5FTE	5.25FTE
	APRN						1FTE	1FTE
	Primary Care Clinicians % FTE						.35FTE	.17FTE
	Registered Nurse						1FTE	1 FTE
	Psych Supervision % FTE						.1FTE	.1FTE
	Project Manager						.5FTE	2.45FTE
	MLADC						1FTE	1FTE
	CHW						3FTE	6FTE
D3	Masters Level clinician (BH)	.75 FTE	Recruit to Hire	1.5 FTE	1.5 FTE	1.5 FTE	1.5 FTE	1.15 FTE .3 FTE Open
	Psychiatry (MD, ARNP)	.1 FTE	Recruit to Hire	.3 FTE	.3 FTE	.3 FTE	.3 FTE	1 FTE
	OB/GYN(ARNP, CNM)	0 FTE	Recruit to Hire	.1 FTE	.1 FTE	.1 FTE	.1 FTE	0FTE
	Pediatrician (MD, ARNP)	0 FTE	Recruit to Hire	.1 FTE	.1 FTE	.1 FTE	.1 FTE	0 FTE
	Case Manager	.4 FTE	Recruit to Hire	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.4 FTE
	Recovery Coach	.5 FTE	Recruit to Hire	.5 FTE	.5 FTE	.5 FTE	.5 FTE	.5 FTE
	Childcare Providers	.3 FTE	Recruit to Hire	.75 FTE	.75 FTE	.75 FTE	.75 FTE	.3 FTE
	Research Assistant	0 FTE						.3FTE
	Data Analyst	0 FTE						.1FTE

	Administrative Support Staff	0 FTE	Hired, Utilizing Current Staff	.5 FTE	.5 FTE	.5 FTE	.5 FTE	0FTE
	Certified Medical Assistant	0 FTE	Hired, Utilizing Current Staff	.5 FTE	.5 FTE	.5 FTE	.5 FTE	0 FTE
C1	Care Transition Coordinator	2 FTE	0- In process to Recruit to hire	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE
	Supervisor	1 FTE	In process to reallocate Current Staff % FTE	1 FTE	1 FTE	1 FTE	1 FTE	1 FTE
E5	Enhanced Care Coordinators	2 FTE	0- In process to Recruit to hire	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE
	Community Case Manager	1 FTE	Recruit to Hire	0 FTE*	1 FTE	Not Currently Staffed Given Project Restructuring- All Contract Positions	Not Currently Staffed Given Project Restructuring- All Contract Positions	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	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.

Many of the recruitment and retention expenditures in July-December, 2019 resulted in partners drawing down on awards from the third phase of the Workforce RFA in the second half of 2019 and use of the remaining funds from early CY2019 awards.

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:

TABLE REDACTED

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.*

Stepping Stone & Next Step Respite Centers and Reality Checks joined as partners in 2018. No change for July- December, 2019 Submission.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Alice Peck Day Memorial Hospital	Hospital Facility	A1, A2, **B1 Core**
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 Core** C1, E5
Child and Family Services	Non CMHC Mental Health Provider	A1, A2, **B1 Support**
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 Core**
Crotched Mountain (includes :)	Community Based Organization Providing Social and Support Services	A1, A2,
Adult Residential Services	Adult Residential Services	A1, A2
ATECH Services	Assistive Technology Clinical Consultation	A1, A2
Community Care	Community Care Management	A1, A2, **B1 Support**
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 Core**
Dartmouth-Hitchcock Dept. of Psychiatry	Non CMHC Mental Health Provider	A1, A2, **B1 Core**, 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 Support**
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 Core**
Mascoma Community Health Center[1]	Integrated Healthcare Provider (not counted as B1)	A1, A2
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 Core**
Monadnock Family Services	Community Mental Health Center	A1, A2, **B1 Core,** 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 Core**
Pathways of the River Valley	Home and Community Based Care Provider	A1, A2
Phoenix House	Substance Use Disorder (SUD) Provider	A1, A2, **B1 Support**
Planned Parenthood of Northern New England - Claremont	Primary Care Practice	A1, A2
Planned Parenthood of Northern New England - Keene	Primary Care Practice	A1, A2
Reality Checks	Other Organization Type	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
Stepping Stone & Next Step Respite Centers	Peer Support – Mental Health	A1, A2, 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 Support , 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 Core, 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 Core, E5

1 We are removing Mascoma Community Health Center from the B1 projects as it has only been operational since mid-Summer 2017 and is currently building their patient base. IDN1 worked to integrate Mascoma Health into the IDN work but the organization has not demonstrated an interest to date. Given the new status of the organization and the many priorities of new health centers the IDN is still working with the organization to determine their role within the IDN long term and specific projects.

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.

3. Please note the classification of B1 partners as either core (subject to Coordinated Care Designation Requirements) and Support (Not subject to project requirements- voluntary participation)

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	6/30/19
A1-3	IDN-level Workforce Capacity Development Implementation Plan	Narrative & Microsoft Project or similar platform	Met	Met	Met	Met	Met
A1-4	Evaluation Project Targets	Table	Met	Met	Met	Met	Met
A1-5	IDN-level Workforce Staffing Targets	Table	Met	Met	Met	Met	Met
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet	Met	Met	Met	Met	Met
A1-7	IDN Workforce Key Organizational and Provider Participants	Table	Met	Met	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

Ongoing IDN HIT Efforts:

Region 1 IDN is happy to report that all A2 targets were met by 12/31/2019. In the latter half of 2019 Region 1 deployed the Collective Medical Technology (CMT) event notification service and shared care plan with the last of our Integrated Care and Coordinated Care Partners. The remainder of organizations needed to meet full A2 HIT targets. Region 1 also continued engagement with hospital organizations who have historically been reluctant to contract for the use of CMT technology.

Technology rollout continues to stay [intentionally] in line with the readiness of our Partner Organizations to engage in care integration projects. Many pilot sites are now in the process of refining workflows and hospital organizations with multiple locations are working to move to scale and expanding patient panels for Event Notifications to monitor hospital utilization. The pace of implementation is slow and steady as the projects continue to get off the ground.

The following is an assessment of IDN-1's progress with our Coordinated and Integrated Care Partners to implement the minimum HIT capabilities identified by the statewide HIT workgroup:

Minimum Requirement – Internet Connectivity: All (12 of 11) Coordinated and Integrated Care Partners meet this requirement.

Minimum Requirement – Secure Data Storage: All (12 of 11) Coordinated and Integrated Care Partners meet this requirement.

Minimum Requirement – Electronic Data Capture: All (12 of 11) Coordinated and Integrated Care Partners meet this requirement.

Minimum Requirement – Direct Secure Messaging: All (11 of 11) Coordinated and Integrated Care Partners meet this requirement. Beyond our target, Region 1 continues to work with Phoenix House to deploy Webmail-based Direct Secure Messaging. As of 12/31/19, DSM is not yet in place.

Minimum Requirement – Shared Care Plan: All (11 of 11) Coordinated and Integrated Care Partners meet this requirement. Beyond our target, Region 1 continues to work with Phoenix House to deploy Collective Medical Technologies for Shared Care Planning. As of 12/31/19, Phoenix House is not an active participant on an IDN project that requires a Shared Care Plan. The contracts are signed and the technology is ready to implement once Phoenix House is engaged through an IDN project.

Minimum Requirement – Data Extraction for Quality Reporting: All (12 of 11) Coordinated and Integrated Care Partners meet this requirement.

Minimum Requirement – Data Sharing Consents All (12 of 11) Coordinated and Integrated Care Partners meet this requirement.

Minimum Requirement – Event Notification: All (11 of 11) Coordinated and Integrated Care Partners meet the requirement for receiving event notifications. Beyond our target, Region 1 continues to work with Phoenix House to deploy Collective Medical Technologies for event notifications. We will continue to promote event notification in tandem with Shared Care Plan once they are actively engaged in an IDN project.

Beyond the core HIT Capabilities, here are the high points of HIT implementation July – December 2019:

1. Region 1 secured Collective Medical Technology contracting among Integrated and Coordinated Care Partner organizations to complete A-2 contract requirements, as well as contracting with two Supporting Community Partners. During the SAR period the following contracts were executed:
    a. New London Hospital – ED and Ambulatory
    b. Alice Peck Day Memorial Hospital – ED and Ambulatory
    c. Monadnock Community Hospital – ED and Ambulatory
    d. Cheshire Medical Center (Dartmouth-Hitchcock Keene) – Ambulatory
    e. Phoenix House – Ambulatory
    f. Lake Sunapee Region VNA and Hospice – Ambulatory (Event Notification only)
    g. Home Healthcare, Hospice and Community Services – Ambulatory (Event Notification only)

2. Region 1 Integrated and Coordinated Care Partner organizations deployed CMT technology to meet, and in some cases exceeded A-2 target goals. During the SAR period the following Partner organizations implemented and are now using CMT technology to support Multi-Disciplinary Care Teams:
    a. Monadnock Community Hospital – Primary Care/Behavioral Health Integration
    b. Cheshire Medical Center (Dartmouth-Hitchcock Keene) – Primary Care/Behavioral Health Integration
    c. Counseling Associates – Behavioral Health partner for Multi-Disciplinary Care Team
    d. Alice Peck Day Memorial Hospital – Primary Care/Behavioral Health Integration
    e. Newport Health Center (New London Hospital) – Primary Care/Behavioral Health Integration
    f. Home Healthcare, Hospice and Community Services – Event Notification only

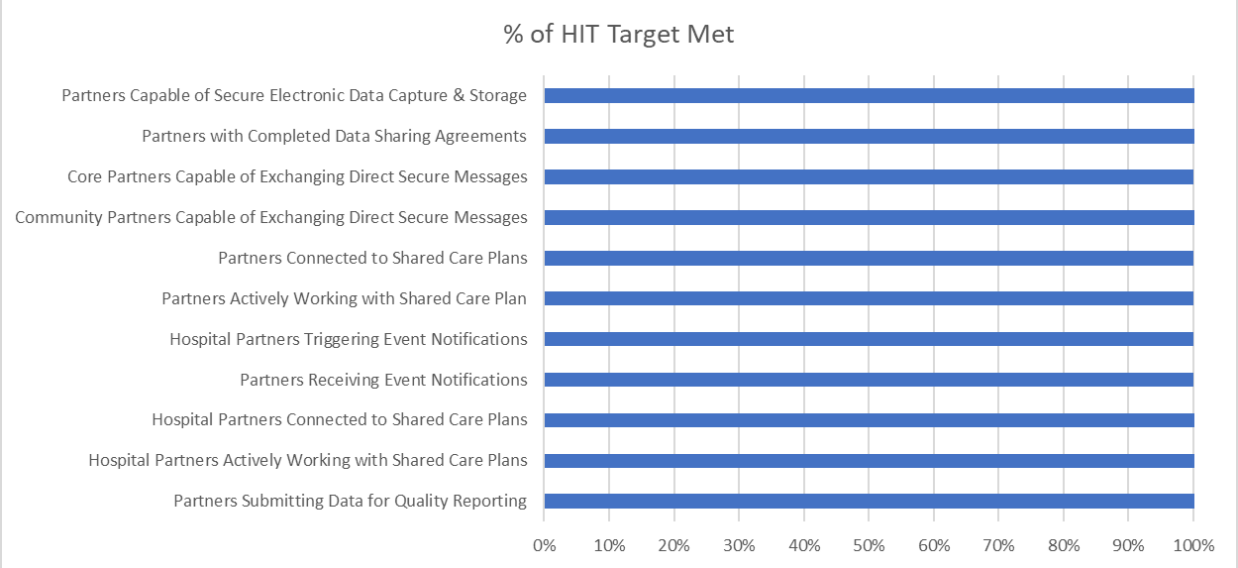
3. Region 1 continues to support new Partners as they onboard around protocols for the Comprehensive Core Standardized Assessment. This includes an 'out of the box' list of questions for organizations beginning from scratch with screening. It also includes a process of screening tool review and IDN-1 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. The Region 1 Data, IT, & Quality Work Group met monthly throughout the period. This was an active forum for Partners to view monthly quality performance dashboards, IT deployment progress, and to share stories and ask questions.

5. 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, December 31, 2019.

Figure 1: Region 1 Progress Relative to HIT Targets as of December 31, 2019



The focus of HIT implementation efforts for the SAR period has been to secure contracting with Partner organizations and deploy use of CMT to B1 project teams to document Shared Care Plans and monitor hospital events needed to meet A-2 targets. 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 deployment of the Collective Medical Ambulatory platform for Shared Care Planning and Event Notification has been slower than planned, however the teams are gaining momentum and many are gearing up to move to scale. 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.

The following dashboard shows the HIT implementation progress to date. The HIT Dashboard is split between IDN-1's Integrated Care Partners and Coordinated Care Partners. Additionally, Community Care Partners may be brought in to provide a vital wrap-around service. 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 and Coordinated Care Partners and Community Supports

Detailed Status – Integrated Care Partners

Organization	Electronic Data Capture & Secured Data	Capable of Direct Secure	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data
Integrated Care Partners							
West Central Behavioral Health							
Dartmouth-Hitchcock Heater Road							
Dartmouth -Hitchcock GIM							
Dartmouth-Hitchcock Psychiatry							
Monadnock Community Hospital							
Coordinated Care Partners							
Valley Regional Hospital							
Monadnock Family Services							
Cheshire Medical Center / DH Clinic Keene							
Counseling Associates							
Alice Peck Day							
New London Hospital / Newport Health Center Practice							
Phoenix House							
Total	12	11	12	11	11	11	12
Target	11	11	11	11	11	11	11
% of Total	109%	100%	109%	100%	100%	100%	109%

Supporting IDN-1 Partners and Organizations

Organization	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications
Child and Family Services					
Crotched Mountain Community Care					
Granite State Independent Living (GSIL)				Not Required	
Headrest					
Home Healthcare, Hospice and Community Services		Not Required		Not Required	
Lake Sunapee Region VNA & Hospice		Not Required		Not Required	
Monadnock Collaborative (Claremont)				Not Required	
Monadnock Collaborative (Keene)					
New Hampshire Hospital				Not Required	
Pathways of the River Valley					
Planned Parenthood of Northern New England - Claremont					
Planned Parenthood of Northern New England - Keene					
Southwestern Community Services				Not Required	
TLC Family Resource Center				Not Required	
Visiting Nurse & Hospice of VT/NH				Not Required	
Total	10	5	2	1	2
Target	9	9	9	9	9
% of Total	111%	56%	22%	11%	22%

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

Detailed Status - Hospitals

Hospital	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Alice Peck Day			
Cheshire Medical Center			
Dartmouth Hitchcock Medical Center			
Monadnock Community Hospital			
New London Hospital			
Valley Regional Hospital			
Total	4	4	4
Target	4	3	2
% of Total	100%	133%	200%

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	Jul '19	Aug '19	Sep '19	Oct '19	Nov '19	Dec '19	Status	Milestone Reporting I
Work Stream 1: Support Partners in Waves									12/31/2019
	Identify remaining Partners to support with HIT							In Progress	12/31/2019
	Recruit and contract with remaining partners (with IDN admin team)							In Progress	12/31/2019
	Milestone: List of Integrated Care, Coordinated Care, and Community Supports							In Progress	12/31/2019

Accomplishments:

- Region 1 continues to work with Integrated Care, Coordinated Care and Community Support Partners as identified through project teams. Specifically, Region 1 successfully engaged Lake Sunapee Region VNA and Hospice as well as Home Healthcare, Hospice and Community Services as community support partners to receive Event Notifications and have access to patients with a Shared Care Plan within the CMT network.

Adjustments to Plan: None

Upcoming Activity: Under new Partner categorizations, we will focus efforts on supporting any new Community Support Partners as needed. Specifically, Region 1 will support Partner organizations as they consider use of CMT as a communication and planning tool with School systems and other Community Partners where “treatment relationship” lines are a bit blurry.

Work Stream 2: Engage Vendors

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

	Deliverable/Milestone	Jul '19	Aug '19	Sep '19	Oct '19	Nov '19	Dec '19	Status	Milestone Reporting Pd
Work Stream 2: Engage Vendors									12/31/2019
	Execute contracts for Pre-Manage ED / Ambulatory - Collective Medical Technology							**In Progress**	12/31/2019
	Facilitate CMT Pre-Manage ED Agreements with Partner Hospitals							**Completed**	12/31/2019
	Milestone: Agreement executed between CMT and New London Hospital							**Completed**	9/30/2019
	Milestone: Agreement executed between CMT and Monadnock Community Hospital							**Completed**	12/31/2019
	Facilitate CMT Pre-Manage Ambulatory Agreements with Partners							**In Progress**	12/31/2019
	Milestone: Agreement executed between CMT and Monadnock Community Hospital							**Completed**	12/31/2019
	Milestone: Agreement executed between CMT and Cheshire Medical Center / DH Keene							**Completed**	9/30/2019
	Milestone: Agreement executed between CMT and APD							**Completed**	9/30/2019
	Milestone: Agreement executed between CMT and New London Hospital							**Completed**	12/31/2019
	Milestone: Agreement executed between CMT and Phoenix House							**Completed**	9/30/2019
	Milestone: Agreement executed between CMT and New Hampshire Hospital							**In Progress**	12/31/2019
	Milestone: Agreement executed between CMT and Lake Sunapee Region VNA & Hospice							**Completed**	9/30/2019
	Milestone: Agreement executed between CMT and Home Healthcare, Hospice and Community Services							**Completed**	9/30/2019
	Execute contracts - Kno-2							**In Progress**	12/31/2019
	Facilitate Kno-2 Agreements with Partners							**In Progress**	12/31/2019
	Milestone: Agreement executed between Kno-2 and Phoenix House							**In Progress**	12/31/2019

Accomplishments:

- CMT agreements executed for use of the Ambulatory system for Monadnock Community Hospital Primary Care and Behavioral Health, Cheshire Medical Center Primary Care, Alice Peck Day Memorial Hospital Primary Care, Newport Health Center (New London Hospital), Phoenix House of Keene, and two community support organizations – Lake Sunapee Region VNA and Hospice and Home Healthcare Hospice and Community Services.
- CMT agreements executed for use of the ED system for New London Hospital and Monadnock Community Hospital
- Kno2 discussions underway with Phoenix House to support Direct Secure Messaging as a means for communication in project work and referrals once actively engaged in a project.

Adjustments to Plan: None

Upcoming Activity: Region 1 completed all contract requirements for use of CMT at the close of the SAR period (July – December, 2019). Region 1 will support any future contracting needs as identified through Partner organizations.

Region 1 will also execute Kno2 contracts as project participation activities occur for Phoenix House and any other Partner organizations in need of Direct Secure Messaging technology to support referrals and care coordination efforts

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.

	Deliverable/Milestone	Jul '19	Aug '19	Sep '19	Oct '19	Nov '19	Dec '19	Status	Milestone Reporting Pd
Work Stream 3: Define Conventions for CCSA, Shared Care Plan, and Referrals									12/31/2019
	Support IDN-1 Protocols Development with HIT Input							**In Progress**	12/31/2019
	Debrief, Collect Learning, and Refine Workflow Conventions							**In Progress**	12/31/2019

Accomplishments:

- Region 1 has completed workflow conventions and developed protocols for CCSAs, Shared Care Plans and Referrals to support services. The CCSA protocol was also expanded to include adolescents.
- Region 1 continues to support participants through development of their own internal workflows to support such practices.
- Region 1 supported several organizations through refinements in CCSA tools, transitions from paper to electronic tablets for improved data collection and workflows for managing responses.

Adjustments to Plan: None

Upcoming Activity: The priority for the next period is to replicate and scale the design work that has been completed to date.

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	Jul '19	Aug '19	Sep '19	Oct '19	Nov '19	Dec '19	Status	Milestone Reporting Pd
Work Stream 4: Ensure Patient Privacy									12/31/2019
	Train Partners in Patient Privacy and Offer Model Forms for Partner Incorporation							**In Progress**	12/31/2019
	Milestone: Partners Trained in Patient Privacy - Wave 3							**In Progress**	12/31/2019
	Execute Data Sharing Agreements with Integrated Care and Coordinated Care Partners							**In Progress**	12/31/2019
	Execute Data Sharing Agreements with Community Supports Partners (as needed)							**In Progress**	12/31/2019

Accomplishments:

- IDN-1 provided Privacy education to Monadnock Community Hospital Primary Care and Behavioral Health, Cheshire Medical Center (Dartmouth Hitchcock Keene) Primary Care, Alice Peck Day Memorial Primary Care, Newport Health Center (New London Hospital), and Monadnock Family Services between July and December 2020.

Adjustments to Plan: None

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. Support Partner organizations as they consider use of CMT as a communication and planning tool with School systems and other Community Partners where “treatment relationship” lines are a bit blurry.

Work Stream 5: Roll Out Shared Technology with Partners

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

Deliverable/Milestone	Jul '19	g '19	Sep '19	Oct '19	v '19	Dec '19	Status	Milestone Reporting Pd
Work Stream 5: Roll Out Shared Technology with Partners								12/31/2019
Deploy Pre-Manage ED Across Region							**In Progress**	12/31/2019
Deploy Pre-Manage ED (ADT Feed)							**In Progress**	12/31/2019
Milestone: Monadnock Community Hospital Sending ADT Feed to CMT							**Deferred**	12/31/2019
Milestone: New London Hospital Sending ADT Feed to CMT							**In Progress**	12/31/2019
Deploy / Train Pre-Manage ED - ED Team Application							**In Progress**	12/31/2019
Milestone: Pre-manage ED in use with Monadnock Community Hospital							**Deferred**	12/31/2019
Milestone: Pre-manage ED in use with New London Hospital							**In Progress**	12/31/2019
Milestone: Pre-manage ED in use with Alice Peck Day							**In Progress**	12/31/2019
Deploy Technical Assistance to IDN-1 Partners							**In Progress**	12/31/2019
Deploy Technical Assistance to IDN-1 Partners							**In Progress**	12/31/2019
Deploy Pre-Manage Community to Integrated Care and Coordinated Care Partners							**In Progress**	12/31/2019
Milestone: Pre-manage Community Connected with DH Pediatrics - Lebanon							**In Progress**	12/31/2019
Milestone: Pre-manage Community Connected with Monadnock Community Hospital							**Completed**	12/31/2019
Milestone: Pre-manage Community Connected with Cheshire							**Completed**	12/31/2019
Milestone: Pre-manage Community Connected with APD							**Completed**	12/31/2019
Milestone: Pre-manage Community Connected with NLH							**Completed**	12/31/2019
Milestone: Pre-manage Community Connected with Phoenix House							**Deferred**	12/31/2019
Deploy Pre-Manage Community to Community Support Partners							**In Progress**	12/31/2019
Milestone: Pre-manage Community Connected with Headrest, Inc.							**Deferred**	12/31/2019
Milestone: Pre-manage Community Connected with Lake Sunapee Region VNA & Hospice							**In Progress**	12/31/2019
Milestone: Pre-manage Community Connected with Home Healthcare, Hospice and Community Services							**Completed**	9/30/2019
Deploy Direct Messaging to Integrated Care and Coordinated Care Partners							**In Progress**	12/31/2019
Milestone: DSM enabled with DH Pediatrics - Lebanon							**In Progress**	12/31/2019
Milestone: DSM enabled with Phoenix House							**Deferred**	12/31/2019
Deploy Direct Messaging to Community Supports Partners							**In Progress**	12/31/2019
Milestone: DSM enabled with HeadRest							**Deferred**	12/31/2019
Deploy Quality Reporting Service (QRS) with Integrated Care and Coordinated Care Partners							**In Progress**	12/31/2019
Train and provide technical support to Partners							**In Progress**	12/31/2019

Accomplishments:

- All A-2 Project Requirements MET
- PreManage EDie Deployment:
    - Monadnock Community Hospital completed ED contract. ADT Feed and EDie Deployment deferred until 2020.
    - New London Hospital ADT feed is in test with CMT. EDie Deployment deferred until July, 2020 when they transition to eDH.
- PreManage Community (Ambulatory) Deployment:
    - The following Partner organizations have *fully deployed* CMT and are using CMT for ENS and/or Shared Care Planning.
        - Monadnock Community Hospital Primary Care and Behavioral Health
        - Cheshire Medical Center (Dartmouth Hitchcock Keene) Primary Care
        - Monadnock Family Services (added Share Care Planning as B1 partner with Cheshire Medical Center)
        - Alice Peck Day Memorial Hospital Primary Care
        - Newport Health Center (New London Hospital)
        - Home Healthcare Hospice and Community Services (ENS only)
    - Below is a status for those Partners who have not yet fully deployed CMT Ambulatory:
        - Phoenix House – deployment deferred until active participation in a B1 project.
        - Lake Sunapee Region VNA and Hospice – Teams are meeting internally to discuss plans for managing the patient enrollment file required for Event Notification. Deployment deferred until Q120.
        - Headrest – CMT contracts fully executed in March, 2019. Deployment efforts delayed until active participation in a B1 project.
    - Dartmouth-Hitchcock Pediatrics in Lebanon is preparing to implement CMT beginning in Q120.
- Direct Secure Message Deployment:
    - Phoenix House – discussions around use of Kno2 for DSM began in June, 2019 and are deferred until active participation in a B1 project.
- All Partners participating in Quality Reporting receive ongoing technical advisory support from the Region 1 to support measure reporting and performance improvement.

Adjustments to Plan:

Establishing active ADT feeds and ED deployment continue to see delays given difficulties with Partner engagement.

Uptake of Direct Secure Messaging continues to lag nationally and in NH. IDN 1 continues to investigate alternatives to point-to-point communication including several new and innovative referral platforms for behavioral health and community supports. IDN 1 will support Partners participating in UniteUs contracts.

Upcoming Activity:

- IDN 1 will work with Monadnock Community Hospital (MCH) to facilitate an ADT feed so that their hospital events can be contributed to the CMT network at large. This is especially important internally, as the Ambulatory providers at Monadnock Community Hospital do not currently have an effective means for receiving notifications of Monadnock Community Hospital's ED and Inpatient related events or for managing hospitalization patterns and reduce utilization.
    - IDN 1 will also facilitate the deployment and training of CMT's EDie product for ED providers at MCH. This is especially important to support the Ambulatory providers in Jaffrey, Rindge, MCH Behavioral Health, and soon New Ipswich, as they document Shared Care plans in the CMT network, often providing helpful plans and interventions for ED's.
- IDN 1 will work with New London Hospital to facilitate the final pieces required for an ADT feed so that their hospital events can be contributed to the CMT network at large. This is especially important internally, as the Ambulatory providers at Newport Health Center do not currently have an effective means for receiving notifications of New London Hospital's ED and Inpatient related events or for managing hospitalization patterns and reduce utilization.
    - IDN 1 will also facilitate the deployment and training of CMT's EDie product for ED providers at New London Hospital. This is especially important to support the team at Newport Health Center, as they document Shared Care plans in the CMT network, often providing helpful plans and interventions for ED's. These activities, however, have been deferred by their ED leadership team until July of 2020.
- Now that B1 project teams across the region are actively engaged and documenting Shared Care Plans in the CMT network, IDN 1 will conduct additional training sessions for ED staff on basic use of the system and discuss how it can be used to support the work happening in the community, and provide teams with opportunities to further collaborate on care.
- Technology deployments on the project teams ramped up heavily in the latter half of 2019. IDN1 will provide ongoing support to Partner organizations are they refine processes and optimize use of the system.
- Direct Messaging is to be deployed with Phoenix House and with Community Supports organizations that are receiving information from Partners.
- Continue to train and support all Partners as needed for all HIT components related to the NH DSRIP project.
- IDN-1 will continue to work with IDN 3, IDN 4, IDN 6, DHHS, and Granite United Way / NH 2-1-1 to reach a decision on deployment of UniteUs. Should contracting proceed, IDN-1 will rapidly deploy UniteUs to support the Sullivan County Community Hub pilot.

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	Jul '19	Aug '19	Sep '19	Oct '19	Nov '19	Dec '19	Status	Milestone Reporting Pd
Work Stream 6: Preparing for Shift to Value Based Payment									12/31/2019
	Support Planning for Shift to Value Based Payment							**In Progress**	12/31/2019
	Inform Payment Model Discussions with HIT Expertise							**In Progress**	12/31/2019
	Adjust HIT Service Offering to Meet Evolving VBP Requirements							**Pending**	12/31/2019
	Provide Ongoing Support to Partners							**In Progress**	12/31/2019
	Provide Ongoing Technology Coordination Support to Partners							**In Progress**	12/31/2019
	Coordinate with Vendor technical support teams to support partners							**In Progress**	12/31/2019
	Assess HIT Technical Supports Needs							**In Progress**	12/31/2019
	Assess HIT Technical Supports relative to Project Requirements							**In Progress**	12/31/2019
	Assess Desired and Optional Requirements Market Readiness							**Pending**	12/31/2019
	Assess New Requirements Stemming from VBP Discussions							**Pending**	12/31/2019
	Adjust HIT Service Offering							**Pending**	12/31/2019
	Adjust HIT Service Offering							**Pending**	12/31/2019
	Provide Technical Assistance based on HIT Service Offering							**Pending**	12/31/2019
	Work with MCOs to Maximize Value of Data Assets for Medicaid Members (optional)							**Pending**	12/31/2019
	Determine role of MCO in IDN Work							**In Progress**	12/31/2019
	Determine MCO data assets that may benefit IDN							**In Progress**	12/31/2019
	Determine Means for Sharing Information among MCOs and IDN							**In Progress**	12/31/2019

Accomplishments:

- The IDN-1 Data, IT, and Quality Workgroup has begun to discuss quality reporting as a stepping stone to Alternative Payment Models.
- IDN 1 provides Advisory support to all Partners who send quality data to the MAeHC Quality Reporting Service. IDN 1 works with teams to familiarize them with reading and understanding DHHS metrics, where they overlap and where they don't with CMS or other quality reporting programs, the importance of data collection, helpful EHR configurations, standardized templates and workflow redesign for improved performance.
- IDN 1 is preparing B1 project teams for official PDSA Quality Improvement projects.
- IDN 1 is in discussions with MCO's to investigate collaboration efforts around data as a means to reduce un-necessary hospitalizations and overall utilization.

Adjustments to Plan: No adjustments.

Upcoming Activity:

- HIT leadership will continue to track payment discussions and will engage as needed.
- IDN 1 will continue to support all efforts noted in Accomplishments.

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	Jul '19	Aug '19	Sep '19	Oct '19	Nov '19	Dec '19	Status	Milestone Reporting Pd
Work Stream 7: Oversee Data & IT with Governance									12/31/2019
	Support Frequent Meetings of the IDN-1 Data & IT Workgroup							Completed	12/31/2019
	Milestone: Data, IT, and Quality Work Group Meeting(s) - Jul 2019							Completed	9/30/2019
	Milestone: Data, IT, and Quality Work Group Meeting(s) - Aug 2019							Completed	9/30/2019
	Milestone: Data, IT, and Quality Work Group Meeting(s) - Sep 2019							Completed	9/30/2019
	Milestone: Data, IT, and Quality Work Group Meeting(s) - Oct 2019							Completed	12/31/2019
	Milestone: Data, IT, and Quality Work Group Meeting(s) - Nov 2019							Completed	12/31/2019
	Milestone: Data, IT, and Quality Work Group Meeting(s) - Dec 2019							Completed	12/31/2019

Accomplishments:

- Region 1 led a monthly Data, IT and Quality Workgroup over the last six months, with the exception of June. Instead in June, Region 1 took a different approach to the meeting and presented performance across each participant organization and each metric. Region 1 presented DHHS targets and a new structure to contracts coming up that will allow organizations participating gin quality reporting to earn additional monies now that we are in a Pay for Performance period.
- 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	As of 6/30/19	As of 12/31/19
# Integrated Care and Coordinated Care Partners Connected to Shared Care Plans	11	2	3	5	7	**11**
# Integrated Care and Coordinated Care Partners Actively Working with Shared Care Plans	11	0	2	4	6	**11**
# Integrated Care and Coordinated Care Partners Receiving Event Notifications	11	0	3	5	8	**11**
# of Integrated Care and Coordinated Care Partners Submitting Data for Quality Reporting (data feed and/or portal)	11	0	7	11	12	**12**
# of Integrated Care and Coordinated Care Partners Capable of exchanging Direct Messages	11	13	12	10	11	**11**
# of Community Support Partners Capable of exchanging Direct Messages	9	6	6	10	10	**10**
# Hospital Partners Sending ADT Messages to ENS	4	3	3	4	4	**4**
# Hospital Partners Connected to Pre-Manage ED	3	1	2	2	3	**4**
# Hospital Partners Actively Working with Pre-Manage ED	2	0	1	2	3	**4**

Note: As part of the December 2018 Semi-Annual Report submission, IDN-1 adjusted the target number of organizations and therefore the number of targets.

- **Figures 2 and 3 shared above on Pg. 26 of this report provide the status of Implementation across IDN1 Integrated Care and Coordinated Cate Partners, as well as Hospitals. These figures provide the detail on the 12 organizations referenced in the A2-4 table for each of the performance measures.**

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	.1 FTE
Data & IT Workgroup Co-Chair (Volunteer)	.05 FTE	.05 FTE	.05 FTE	.05 FTE	.05 FTE
Director of Data & IT (IDN Contracted)	.85 FTE	.85 FTE	.85 FTE	.85 FTE	.85 FTE
Implementation Specialist (IDN Contracted)	.35 FTE	.35 FTE	.35 FTE	.35 FTE	.35 FTE

A2-6. IDN HIT: Budget

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 Data and IT Director for advisory and subject matter expertise in health information exchange and the IDN-1 technical services support.
- 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:

Project to which budget is assigned	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actual	CY 2019 Actual	CY 2020 Projected	CY 2021 Projected	Total
Salary & Benefits	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Technology	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Sub-Contract	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Occupancy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Travel	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	**125,445**	**443,965**	**766,842**	**308,820**	**265,296**		**1,910,369**

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

TABLE REDACTED

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

COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

IDN-1

Health Information Technology

July - December 2017

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	$ 241,377.59	$ -	$ 241,377.59	

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

COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

IDN-1

Health Information Technology

January - June 2018

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	**$ 390,103.75**	**$ -**	**$ 390,103.75**	

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

COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

IDN-1

Health Information Technology

July - December 2018

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	**$ 376,738.66**	**$ -**	**$ 376,738.66**	

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

COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

IDN-1

Health Information Technology

January - June 2019

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	$ 127,902.83	$ -	$ 127,902.83	

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

COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

IDN-1

Health Information Technology

July - December 2019

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	**$ 180,917.66**	**$ -**	**$ 180,917.66**	

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

COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

IDN-1

Health Information Technology

January - June 2020

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	$ 179,246.38	$ -	$ 179,246.38	

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

COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

IDN-1

Health Information Technology

July - December 2020

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	**$ 86,049.42**	**$ -**	**$ 86,049.42**	

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
Integrated Care Partners	
West Central Behavioral Health	Community Mental Health Center
Dartmouth-Hitchcock Lebanon	Primary Care Provider, Hospital
Dartmouth-Hitchcock Psychiatry	Mental Health Provider
Monadnock Community Hospital	Primary Care Provider, Hospital
Coordinated Care Partners	
Valley Regional Hospital	Primary Care Provider, Hospital
Monadnock Family Services	Community Mental Health Center
Cheshire Medical Center / DH Clinic Keene	Primary Care Provider, Hospital
Counseling Associates	Mental Health Provider
Alice Peck Day	Primary Care Provider, Hospital
New London Hospital / Newport Health Center Practice	Primary Care Provider, Hospital
Phoenix House	SUD Treatment Provider

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
Counseling Associates	Y
Crotched Mountain Community Care	Y
Dartmouth-Hitchcock Clinic Lebanon	Y
Dartmouth Hitchcock Keene (Cheshire Medical Center)	Y
Dartmouth-Hitchcock Psychiatry	Y
Headrest	Y
Monadnock Community Hospital - Primary Care	Y
Monadnock Family Services	Y
New London Medical Group Practice	Y
New London Pediatric Care Center Practice	Y
Newport Health Center Practice	Y
Phoenix House	Y
TLC Family Resource Center	Y
Valley Regional Hospital - Primary Care	Y
West Central Behavioral Health	Y

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	6/30/19	12/31/19
A2-3	IDN HIT/HIE Implementation Plan and Timeline	Narrative & Spreadsheet	Met	Met	Met	Met	Met	Met
A2-4	Evaluation Project Targets	Table	Met	Met	Met	Met	Met	Met
A2-5	IDN HIT Workforce Staffing	Table	Met	Met	Met	Met	Met	Met
A2-6	IDN HIT Budget	Narrative & Spreadsheet	Met	Met	Met	Met	Met	Met
A2-7	IDN HIT Key Organizational and Provider Participants	Table	Met	Met	Met	Met	Met	Met
A2-8	IDN HIT Data Agreement	Table	Met	Met	Met	Met	Met	Met

Project B1: Integrated Healthcare

Please note throughout the B1 Project Section tables as well as other sections of the report there are notations after each organization name indicating B1 Core Partner (indicating that this organization is required to meet CCD requirements) or B1 Support Partner (indicating that this organization is NOT required to meet CCD requirements).

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

See Appendix B1-2 for Excel Work plan of B1 Activities

Narrative

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

Include a detailed narrative which speaks to the progress each participating practice has made within the reporting period include progress toward the Integrated Care Practice Designation

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

B1 Requests for Proposals (RFP) and Implementation Waves

Overview of the IDN1 Process: *As reported in previous SAR reporting*

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. Primary Care and Behavioral Health practices, as captured in the Region 1 IDN attribution, has participated in the B1 project. Teams have on boarded in "waves", with various starting of implementation. This has allowed 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 RFP 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 RFP processes and structures were reviewed and endorsed by the Executive Committee. As each new wave of RFPs were released, the administrative team updated the documents and processes. In the later waves, the administrative teams worked closely with practices still pending on boarding to more closely address the teams goals and needs. After careful review, the IDN administrative 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.

In total the IDN 1 team on boarded six B1 organizations with three supporting behavioral health organizations and two substance use disorder organizations. A grid of project onboarding can be found below. Due to the complex nature and size of each individual, their approach to implementation and spread within the organization is completely variant.

The focus for the supporting behavioral health organizations for the past six months has focused on increasing their access to all IDN partners. West Central Behavioral Health now sits at seven Multi-Disciplinary Care Team tables. The focus for the primary care teams in CY 2019 was improving and spreading of existing projects. In July 2019, all contracts were renewed for the final 18 months of the waiver, placing all B1 contracts on the same evaluation and payment time frame. Built into the contracts were parameters for teams receiving core funding and the ability for teams to collect incentive dollars, based on their contribution to the pay for performance metrics.

Project Team	Start Date
Alice Peck Day	Fall 2018
Cheshire Medical Center	Bi-Directional project - Summer 2018 CMC Primary Care – Summer 2019
Dartmouth Hitchcock	Heater Road South – Summer 2017 GIM – January 2019 Pediatric – June 2019 Heater Road North – Summer 2019
Monadnock Community Hospital	Summer 2018
Newport Health Center	Summer 2018
Valley Regional Hospital	Fall 2017
Support Behavioral Organizations	
Counseling Associates	Fall 2017
Monadnock Family Services	Fall 2017
West Central Behavioral Health	Fall 2017
Headrest	Fall 2017
Phoenix House	Fall 2017

B1 Dartmouth-Hitchcock (DH) Heater Road and General Internal Medicine (GIM) Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care

See appendix B1-2: Dartmouth Hitchcock Heater Road and GIM for updated Workplan (July-Dec, 2019)

Project Overview

DH Heater Road was the pilot team for the region, starting to develop the work for many of the requirements. The system quickly on boarded the GIM department which was operating in their own project space. As the teams finished the planning and implementation portions of their worked and moved into improvement, it was decided it would be more valuable to merge the team work together, improving time commitment and shared learning. As the next year passes, the team will also integrate the pediatric team into the shared management and coordinated care meetings. The unique aspect of these teams was the hiring of the Care Team Coordinator which supports the MDCTs and SCPs as well as managing and facilitating relationships with outside partner organizations.

Current State: July 1, 2019 – December 31, 2019

Project Workflows and Team Development:

As of December 31st, 2019 all adult primary care teams are support by the care team coordinator (CTC), community health worker (CHW) and behavioral health clinician (BHC) roles. DH psychiatry is also a regular member of the project team. While not financially supported by the IDN, the team has actively involved both the RN care coordinator and medical assistant roles.

- Over the course of the six month period, Heater Road North was on boarded to all aspects of B1 work and are actively screening with the CCSA and have been presenting patients at the monthly MDCTs.
- The two primary care teams (Heater Road and GIM) went through a period of meeting restructuring in the late fall, winter of 2019. In the first cycle each team would meet individually every month with a quarterly system level meeting. After further review, it was decided that the teams would meet together once a month. Content at both meetings were duplicative. Combining the teams to one meeting has increased the shared learning and improved alignment/standardization for the system.
- During the last few months of the semi-annual period, the IDN Integrative Director and Program manager met with the CTC to support the transition of project team facilitation and project management. During the first few months of the New Year, they will continue to support this role in onboarding these new skills and responsibilities, eventually transitioning to a place of consultation.
- The teams have worked diligently to onboard additional behavioral health and social support organizations to their MDCT. As a result, West Central Behavioral Health no longer attends the project team meetings, as the focus is now more internal. In the past few months, the MDCT has welcomed Pathways to the table as well as personnel from the Emergency Department. In the last year of the Waiver, the team will be onboarding Headrest, Counseling Associates, the Addition Treatment Program (ATP) at Dartmouth.

- The Care Team Coordinator and IDN administration has been working with leaders in the emergency department (ED) to better include them in the treatment team. It has improved referrals for the MDCT as they are able to better identify patients who frequent the ED. They hope to improve upon this as the DH system uploads their entire Medicaid panel into CMT. Additionally, the ED personnel has been identifying patients who frequent the ED but are medically homed with different organizations. With close support from the IDN administrative team, the CTC and DH leaders are working to identify a process to refer these in order to be addressed with other organization's MDCTs where they are medically homed.
- The Care Team Coordinator continues to be located at WCBH 1 day weekly and participates in team meetings there where possible. This fosters a closer coordination with the WCBH staff and inclusion in the ongoing project development. The CTC has continued to broaden and strengthen relationships with WCBH clinicians, team leads and data staff
- The teams continuing to meet and improve undertaking efforts to continually progress their integration efforts. They completed another round of the Site Self-Assessment in October of 2019 (results below). While the teams have both improved, they both have areas they continue to work on. The Dartmouth system has adopted the Collaborative Care Model of Integration, and while they have established the framework, there biggest opportunity's for improvement is insure the whole care team is better integrated together, and ensuring better patient engagement.

Site Self-Assessment (SSA) Practice-Level Report

For IDN Region Number: 1 | And IDN Practice Number: 1-106

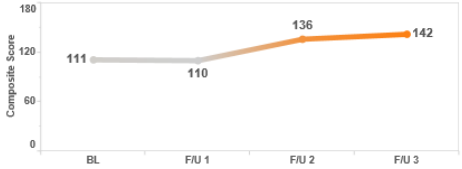
Average Scores: Domain One
Intergrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2	F/U 3
1. Level of integration: primary care and mental/behavioral health care	7	8	8	9
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance a..	7	8	7	8
3. Treatment plan(s) for primary care and behavioral/mental health care	7	8	8	9
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	6	7	7	7
5. Patient/family involvement in care plan	7	6	7	8
6. Communication with patients about integrated care	7	6	6	7
7. Follow-Up of assessments, tests, treatment, referrals and other services	7	6	8	7
8. Social support (for patients to implement recommended treatment)	6	6	7	9
9. Linking to community resources	6	5	8	9

Average Scores: Domain Two
Practice/Organization

	BL	F/U 1	F/U 2	F/U 3
1. Organizational leadership for integrated care	7	6	9	8
2. Patient care team for implementing integrated care	6	5	9	9
3. Providers' engagement with integrated care ("buy-in")	7	6	7	7
4. Continuity of care between primary care and behavioral/mental health	6	5	7	8
5. Coordination of referrals and specialists	6	6	9	9
6. Data systems/patient records	7	8	9	8
7. Patient/family input to integration management	4	4	7	6
8. Physician, team and staff education and training for integrated care	4	5	6	7
9. Funding sources/resources	4	5	7	7

Composite Score Progression



Note:
BL - Baseline Assessment
F/U 1 - First Follow-Up Assessment
F/U 2 - Second Follow-Up Assessment
F/U 3 - Third Follow-Up Assessment

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10/8/2019

Site Self-Assessment (SSA) Practice-Level Report

For IDN Region Number: 1 | And IDN Practice Number: 1-123

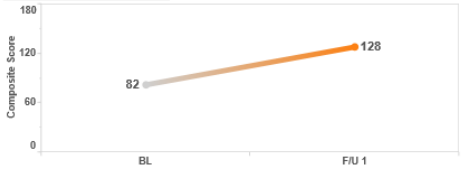
Average Scores: Domain One
Intergrated Services and Patient and Family Centeredness

	BL	F/U 1
1. Level of integration: primary care and mental/behavioral health care	6	7
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance a..	7	7
3. Treatment plan(s) for primary care and behavioral/mental health care	5	7
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	5	8
5. Patient/family involvement in care plan	4	7
6. Communication with patients about integrated care	4	7
7. Follow-Up of assessments, tests, treatment, referrals and other services	5	7
8. Social support (for patients to implement recommended treatment)	3	8
9. Linking to community resources	4	8

Average Scores: Domain Two
Practice/Organization

	BL	F/U 1
1. Organizational leadership for integrated care	6	7
2. Patient care team for implementing integrated care	4	7
3. Providers' engagement with integrated care ("buy-in")	5	6
4. Continuity of care between primary care and behavioral/mental health	5	8
5. Coordination of referrals and specialists	4	7
6. Data systems/patient records	5	7
7. Patient/family input to integration management	2	6
8. Physician, team and staff education and training for integrated care	4	7
9. Funding sources/resources	4	7

Composite Score Progression



Note:
BL - Baseline Assessment
F/U 1 - First Follow-Up Assessment
F/U 2 - Second Follow-Up Assessment
F/U 3 - Third Follow-Up Assessment

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10/8/2019

- The team continues to meet all quarterly evaluation milestones. See below:

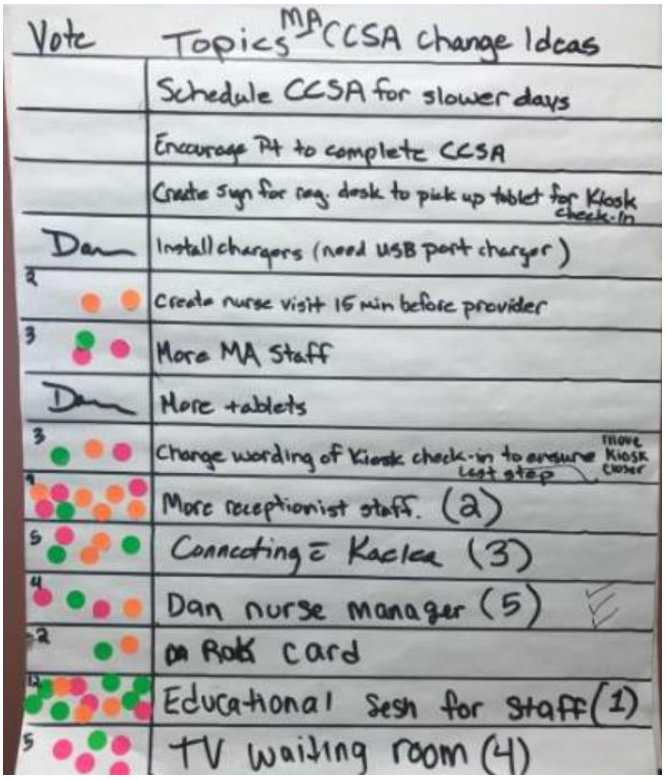
Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	IDN Activities: Baseline participation Met or Unmet
Q1 Y3: July 1, 2019- September 30, 2019						
Heater Road Practice Team	*Milestone 1* : Utilization of SCP for all indicated high acuity patients	SCP Quarterly Data	Met	Met	Met	Met
	Milestone 2 : Adherence to CCSA response protocol	CCSA Quarterly Data	Met			
	Milestone 3 : MDCT meetings held monthly (at minimum)	Meeting Calendar	Met			
	Milestone 4 : Utilize Data and SSA to Improve Integration Efforts	Meeting Notes	Met			
	Milestone 5: Onboard Additional Community Partner to MDCT	Supporting Documents	Met			
Q2 Y3: October 1, 2019- December 31, 2019						
Heater Road Practice Team	*Milestone 1* : Utilization of SCP for all indicated high acuity patients	SCP Quarterly Data	Met	Met	Met	Met
	Milestone 2 : Adherence to CCSA response protocol	CCSA Quarterly Data	Met			
	Milestone 3 : MDCT meetings held monthly (at minimum)	Meeting Calendar	Met			
	Milestone 4 : Utilize Data and SSA to Improve Integration Efforts	Meeting Notes	Met			
	Milestone 5: Onboard DHMC Psych to MDCT	Supporting Documents	Met			

Project Name, Le	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
Y2 Q1: July 1, 2019 - September 30, 2019						
DHMC: GIM	*Milestone 1: Utilization of SCP for all indicated high acuity patients*	SCP Quarterly Data	Met	Met	Met	Met
	Milestone 2: Adherence to CCSA response protocol	CCSA Quarterly Data	Met			
	Milestone 3: MDCT meetings held monthly (at minimum)	Meeting Calendar	Met			
	Milestone 4: Utilize Data and SSA to Improve Integration Efforts	Meeting Notes	Met			
	Milestone 5: Onboard Additional Community Partner to MDCT	Supporting Documents	Met			
Y2 Q2: October 1, 2019 - December 31, 2019						
DHMC: GIM	*Milestone 1* : Utilization of shared care plan for all indicated high acuity patients	SCP Quarterly Data	Met	Met	Met	Met
	Milestone 2 : Adherence to CCSA response protocol	CCSA Quarterly Data	Met			
	Milestone 3: MDCT meetings held monthly (at minimum)	MDCT Meeting Calendar	Met			
	Milestone 3 : QI Project 1, 2 : Screening and Follow Up, ED Utilization	QI Documents showing quarter progress	Met			
	Milestone 4 : Onboard additional partners	Demonstrate progress with partner communication	Met			

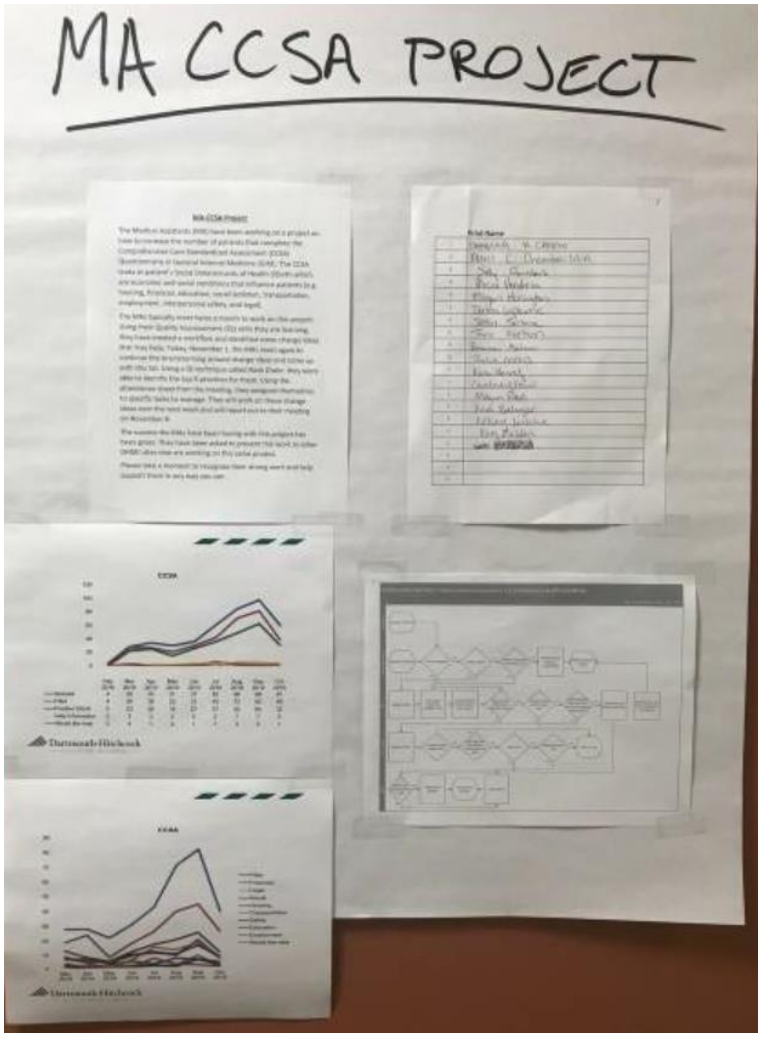
CCSA

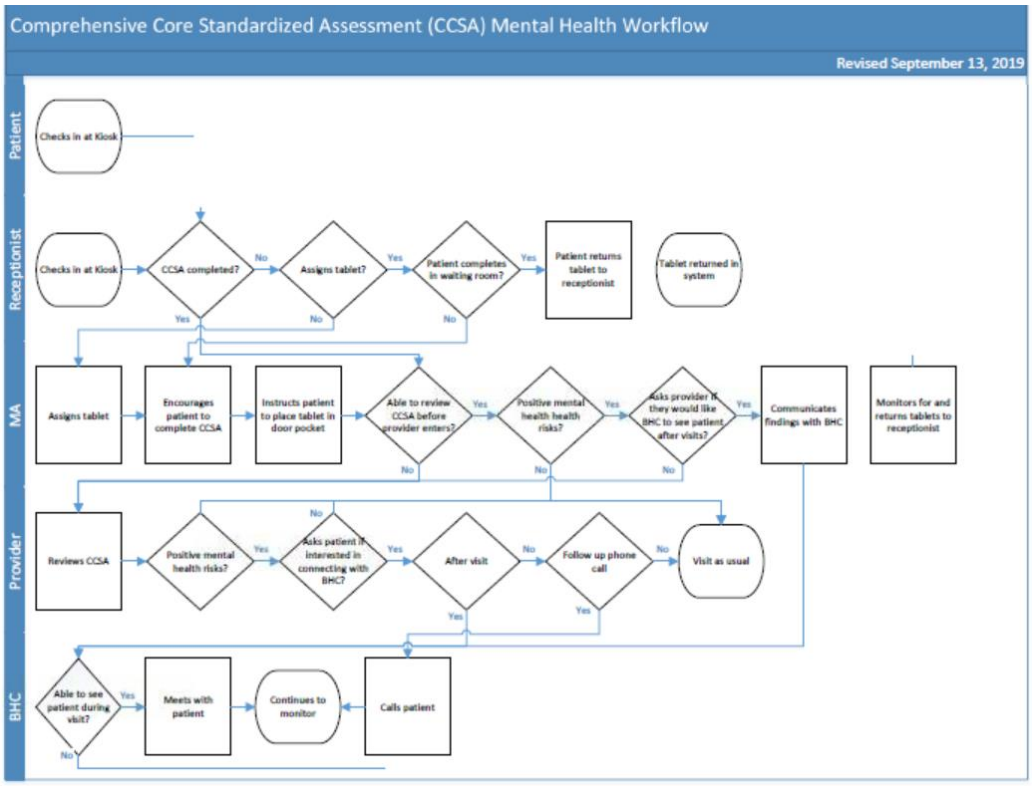
- The Comprehensive Core Standardized Assessment is now well established in all Dartmouth Hitchcock Medical Center (DHMC) primary care departments. The team is focusing on improving their rates through a few different approaches. The DHMC data team has been working diligently on improving the quality of their data reporting and working with the on the ground teams to ensure alignment between documentation and reporting.
- The team reviews quality data for Assess 01 – Use of the CCSA on a monthly cadence and conducts periodic Plan-Do-Study-Act (PDSA) quality improvement cycles with the measurement feedback. In the next year the teams will take a deeper dive into process improvement and

utilization of other project tools to continue to improve their screening and follow-up. The provider champion for GIM has been leading a group of medical assistants (MAs) in improving the workflow. Below are some of the tools they used to support their improvement efforts.



Vote	Topics MA CCSA change Ideas
	Schedule CCSA for slower days
	Encourage Pt to complete CCSA
	Create sign for reg. desk to pick up tablet for Kiosk check-in
Dan	Install chargers (need USB port charger)
2	Create nurse visit 15 min before provider
3	More MA Staff
Dan	More tablets
3	Change wording of Kiosk check-in to ensure last step; move Kiosk closer
4	More receptionist staff. (2)
5	Connecting ∈ Kaelea (3)
4	Dan nurse manager (5)
2	Rolo card
12	Educational sesh for staff (1)
5	TV waiting room (4)


MA CCSA PROJECT



- Finally, the team continues to review the pathway data to look for opportunities to improve. As they finished the onboarding of the CCSA for Heater Rd North and the GIM residents, they now have a more comprehensive view of their population needs.

Pathways from inception to December 31, 2019 *(Source: REDCap data)*

		Baby/ Family Support	Behavioral Health	Child Care	Dental	Education	Employme..	Fast Track	Financial Assistance	Food Insecurity	Health Education	Health Insurance	Housing	Interpersonal Safety	Legal	Medical Home	Other Client Goal	Provider Initiated	Transport..	Grand Total
Leb GIM	Started		14		1		1	4	20	15	2	12	25		3	1	20	3	6	127
	Completed		5		1		0	4	8	11	0	6	6		2	0	7	2	4	56
	Not Completed		1		0		0	0	0	0	0	1	3		0	0	5	0	0	10
	Open		8		0		1	0	12	4	2	5	16		1	1	8	1	2	61
Leb Heater Road	Started	4	6	1	9	2	10	28	88	58	1	46	80		6	7	52	4	36	438
	Completed	3	4	0	2	1	6	28	39	36	1	24	27		4	3	27	2	19	226
	Not Completed	0	0	1	2	0	0	0	13	4	0	6	8		1	0	4	1	3	43
	Open	1	2	0	5	1	4	0	36	18	0	16	45		1	4	21	1	14	169

- As you can see in the data, the top pathways for referrals including housing and financial assistance. Housing continues to be a struggle to close as the resources in the Upper Valley are limited

MDCT & SCP

- The Heater Road and GIM team each meet once monthly for their MDCTs. As they look to onboard additional partners they are looking at how to restructure these sessions managing provider availability, multiple partners and the privacy boundaries of shared care plan review.

- As the teams look at the final year of the Waiver, they have reviewed their data around the SCPs in use and MDCTs and will look to improve the number of cases being review and the number of partners at the table. They will also look to revisit their criteria for patient review at an MDCT.
- The teams have decided instead of closing cases once a patient is deemed "stable" to move back to a quarterly or annual review to ensure continuity in care. They only criteria for closing a case is if the patient has discharged from service.

MDCT Data 2019 - Heater Rd	January	February	March	April	May	June	July	August	September	October	November	December	Total
Number of MDCTs Mtgs	1	1	1	1	1	1	1	1	1	1	1	0	11
Number of New SCPs	0	1	0	0	1	1	0	0	1	0	0	3	7
Number of closed SCPs	0	0	0	0	0	0	0	0	0	1	0	0	1
Number of Reoccuring SCPs	3	2	3	3	2	3	4	5	5	5	3	3	
Number of Total Active Shared Care Plans	6	7	7	7	8	9	9	9	10	9	9	12	
Number of External Partners	0	0	0	0	0	0	0	1	1	1	0	0	
Onboarding of External Partners (please indicate with an X when external partner first joined an MDCT)													
West Central Behavioral Health	X												
Pathways								X					

MDCT Data 2019 - GIM	January	February	March	April	May	June	July	August	September	October	November	December	Total
Number of MDCTs Mtgs	1	1	1	1	1	1	1	1	1	1	1	1	12
Number of New SCPs	0	2	1	0	1	1	0	1	0	0	2	1	9
Number of closed SCPs	0	0	0	0	0	0	0	0	1	0	0	0	1
Number of Reoccuring SCPs	0	0	0	3	3	4	3	4	3	1	3	1	
Number of Total Active Shared Care Plar	0	2	3	3	4	5	5	6	5	6	8	9	
Number of External Partners	0	0	0	0	0	0	0	1	1	1	0	0	
Onboarding of External Partners (please indicate with an X when external partner first joined an MDCT)													
West Central Behavioral Health			X										

Timeline for Remaining Implementation to CCD:

- As of reporting submission the team has met Coordinated Care Designation and Integrated Care Designation. The team will continue to work on improving their implemented projects while looking at additional opportunities for improving integration with the support of data and continues Site-Self Assessment evaluations.

B1 Dartmouth Hitchcock- Pediatrics Practice Coordinated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care)

Project Overview

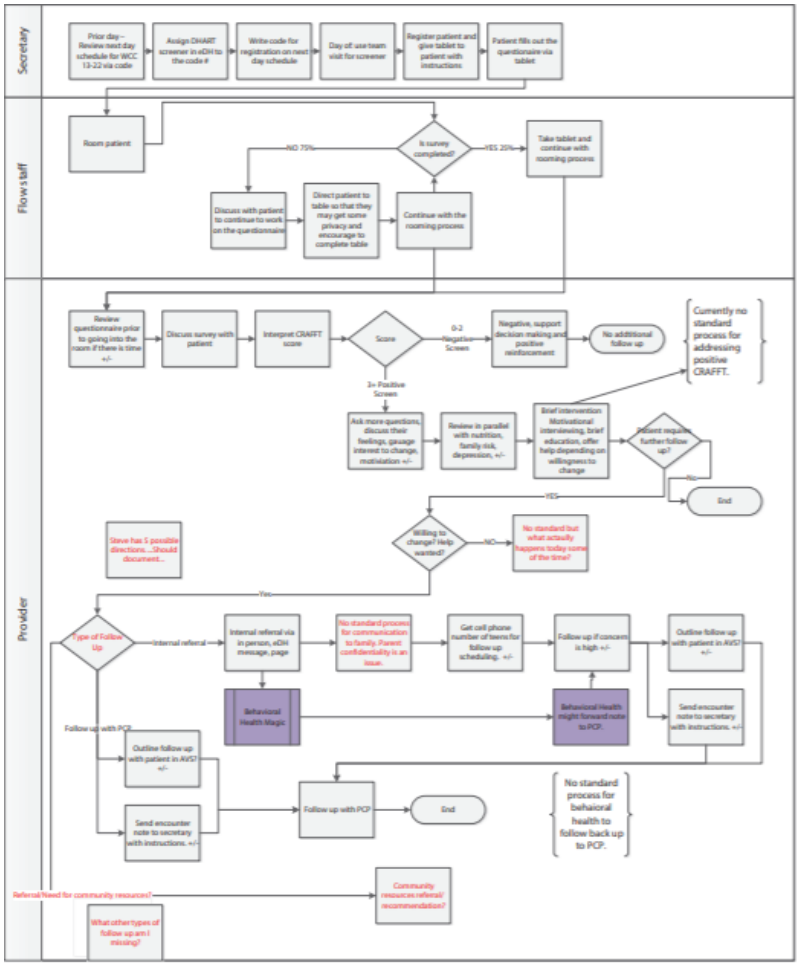
The DHMC-Lebanon pediatric team has been meeting regularly since the summer of 2019. Over the course of the past six months, the team has reviewed their process flow for the DART screen (which meets the CCSA requirements) and identified opportunities for improvement. The team is placing greater focus on other components of the requirements.

Current State: July 1, 2019 – December 31, 2019

In December of 2019, the pediatric team on boarded there Care Team Coordinator (CTC), which will also be responsible for the project management of the project. The team's area of most concentrated focus is supporting the development of the monthly MDCT, The team, like the others within the project portfolio, has started out slowly with identifying one patient for review initially in partnership with West Central

Behavioral Health. The CTC has begun to create a list of possible patients for future review. The team would also like to incorporate the school system in the near future to the MDCTs as well. IDN administration is currently working on the confidentiality barriers and next steps to support the team to work towards this.

- Early in the reporting period, the team reviewed their existing screening workflow, and identified possible opportunities for improvement. While the data team works to isolate their screening rates, the team is planning to move forward on this after the MDCT become more stable. Below is their current state workflow.



- The team would also like to onboard a more permanent community health worker. Currently their community health worker is funded through AmeriCorps. This has prevented them for collecting the same level of data as they do in the other departments since they do not utilize REDCAPPS. The team is determining how to onboard the position in conjunction with the AmeriCorps position.
- The IDN is supporting the increased capacity of Molly's place which sits inside the pediatric department. This program supports families in better connecting patients with social services they may need to address social determinants of health.

Quarterly evaluation milestones below:

Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Dartmouth Hitchcock Medical Center: Pediatrics	*Milestone 1*: Process Map Screening and follow-up workflow	Process Map	Met	Met	Met	Met
	Milestone 2: Purchase Bright Futures Screenings	Screening materials	Met			
	Milestone 3: Post positions for hire	Job Description	Met			
	Milestone 4: Complete SSA	SSA results	Met			
Y1 Q2: October 1, 2019 - December 31st, 2019						
Dartmouth Hitchcock Medical Center: Pediatrics	*Milestone 1*: Onboard CMT for Pediatric Team	Notes on Team Members Access and Training	Met	Met	Met	Met
	Milestone 2: Determine Approach for MDCT Patient Elevation	Notes on Approach, PDSAs is applicable	Met			
	Milestone 3: Finalize Deliverables for MDCT	Workflow, Protocol	Met			
	Milestone 4: Onboard CTC	Onboarding schedule	Met			

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

See appendix B1-2: VRH/CA for updated Workplan (July-Dec, 2019)

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. With the complete implementation of care coordination designation components successfully implemented in all primary care clinics, the team has expanded external partnerships with Counseling Associates, West Central Behavioral Health, Groups, the local school system and other social service agencies.

Current State: July 1, 2019 – December 31, 2019

Project Workflows and Team Development

- The team transitioned to monthly formal project meetings over the reporting period with leadership meeting more frequently.
- The project team has representation from each of the clinics. As the year closed, leadership assessed and determined there were too many staff attending regularly In the New Year they will restructure the project team for efficiency and quality.
- The clinical team is now well staffed with two master level social workers (MSW) and one community health worker (CHW) addressing the positive CCSAs and interacting with other clinical staff in an integrated way.
- The leadership team transitioned their office nurse to an RN care coordinator at the end of the reporting period. This is a new position for their outpatient clinic and will allow for better continuity of care for the patients in helping to coordinate the medical and behavioral health needs of the patient. This position will also be responsible to reviewing CMT data once the team uploads their Medicaid panel.

- The team has completed and works off of a charter, and work-plan milestone document that guides their implementation timelines
- The behavioral health organizations no longer attend the project team meeting due to their active participation with the ongoing MDCTs. The team has formulated a new process within their relationships to continue to improve care transitions can closed loop referrals. VRH has additionally expanded the relationships with Groups, the local school system and several social service agencies.
- The VRH team completed their fourth round of the site self-assessment, having improved which each round. While the team has implemented all CCD component across primary care, they are very critical about their level of integrated achievement. They continuously work to improve the culture of whole patient care, utilizing the new transformation they have implemented.

Site Self-Assessment (SSA) Practice-Level Report

For IDN Region Number: 1 | And IDN Practice Number: 1-120

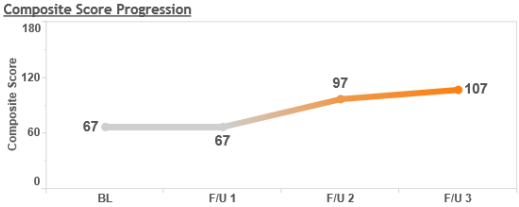
Average Scores: Domain One
Intergrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2	F/U 3
1. Level of integration: primary care and mental/behavioral health care	2	2	4	5
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance a..	4	4	5	9
3. Treatment plan(s) for primary care and behavioral/mental health care	4	4	4	7
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	4	4	5	7
5. Patient/family involvement in care plan	4	4	5	7
6. Communication with patients about integrated care	3	3	5	6
7. Follow-Up of assessments, tests, treatment, referrals and other services	3	3	5	7
8. Social support (for patients to implement recommended treatment)	3	3	6	7
9. Linking to community resources	3	3	7	8

Average Scores: Domain Two
Practice/Organization

	BL	F/U 1	F/U 2	F/U 3
1. Organizational leadership for integrated care	8	8	7	8
2. Patient care team for implementing integrated care	3	3	6	7
3. Providers' engagement with integrated care ("buy-in")	8	6	6	3
4. Continuity of care between primary care and behavioral/mental health	4	4	5	7
5. Coordination of referrals and specialists	4	4	5	5
6. Data systems/patient records	6	6	5	3
7. Patient/family input to integration management	1	3	5	3
8. Physician, team and staff education and training for integrated care	2	2	6	6
9. Funding sources/resources	1	1	6	2

Composite Score Progression



Note:
BL - Baseline Assessment
F/U 1 - First Follow-Up Assessment
F/U 2 - Second Follow-Up Assessment
F/U 3 - Third Follow-Up Assessment

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Institute for Health Policy & Practice
Maine Health Access Foundation. Site Self-Assessment. Updated 2016

10/8/2019

- The project team continues to look at opportunities for tele psychiatry. The team has been challenged with finding available clinicians to meet this need especially for the pediatric population. Where the demand for psychiatry is high in the region, with few resources, this is a challenge faced by many teams, even with funds to support the implementation.
- In the fall of 2019, the VRH MSWs provided a training to the staff on mental health topics to better support them in addressing patient needs in a time of crisis. Below is their presentation.

Valley Regional Healthcare

Basic Mental Health Administrative Training

By: Krista LaFont-Leamey, MSW
Danielle Tenney, MSW

What is Behavioral Health?

- What do you think of when you hear the term Behavioral Health?
- Why do we care about behavioral health in primary care?

SAMHSA Definition

- "Behavioral Health is the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders, and the support of those who experience and/or are in recovery from these conditions"

What is Mental Health?

- What is mental health?
- What do people with mental illness look like?

What is substance misuse?

- What does "substance" mean in this case?
- What does it mean to misuse substances?
- What do people look like when they are misusing substances or are addicted to substances?

Common Types of Mental Health Struggles

- Depression
- Anxiety
- Psychosis
- Thoughts of being better off dead or of killing oneself (suicidal thoughts)

What does depression look like?

- Changes- people seem "different" than they did before.
- They may seem sad, "flat", disheveled, have poor personal hygiene, be irritable, have slower than normal speech, and miss or cancel appointments.
- These signs may all be present or none of them may be present. There may be other changes that you see that are not on this list.

Screening for Depression

- We screen for depression because death by suicide is preventable.
- We screen for depression because it impacts a person's whole existence, including physical health.
- We screen for depression because people don't need to suffer. We can help!

Screening Tools

- We have depression screening tools embedded in the B1 screening forms
- Adult forms- The PHQ-9 (Patient Health Questionnaire 9).
- Youth forms- The PHQ-A (Patient Health Questionnaire Adolescent).
- Parent form- MFQ short version parent form (Mood and Feeling Questionnaire)

What can Anxiety look like?

- Changes in people's behaviors or attendance.
- People may seem: on edge, irritable, show signs of perfectionism, express unreasonable fears, "fidget" or always move. They may talk faster than normal. They may seem unreasonable. They may complain of stomach or head aches.
- They may have all of these signs or none of them. Each person is unique

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Why do we screen for Anxiety?

- Anxiety can lead people to feel suicidal. Death by suicide can be prevented.
- Anxiety can lead to physical health issues.
- Anxiety can lead to problems at work, and in relationships.
- Anxiety is treatable. It can be treated with medication and/or counseling. Peer support and mindfulness are also helpful.

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How do we screen for Anxiety?

- The adult (blue) form and the youth (yellow) form screen for anxiety.
- The GAD-7 (Generalized Anxiety Disorder-7) screener is embedded in each form.
- This screener can alert providers to the possibility of anxiety.

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What is Psychosis?

- Psychosis is disordered thinking where someone may think things that are not true (delusions), or experience things that are not there (hallucinations). Hallucinations can be heard, seen, smelled, felt on the skin, or tasted.
- People with psychosis have a higher rate of being victims of violence than the general population.

What might psychosis look like?

- You may not be able to tell that someone is experiencing psychosis.
- People may have: slow reactions in conversations, be distracted, wear "odd" clothing, talk to themselves (or no one), have a "flat" look, sometimes wear sunglasses or hoodies inside.

How can we help?

- Be kind and don't argue.
- Be patient.
- Don't be afraid- people with psychosis are less likely to be violent than the general population.
- Psychosis can be treated with medication, peer support and case management.

Stigma

- Long history of fear, discrimination, and mistreatment.
- Stigma is still strong in many cultures
- Stigma leads to shame, fear of disclosing, and fear of being viewed as less than others. There can be an internal belief that they are not worthy.

Battling Stigma

- People first language- "Person with a Disability", "Person with Schizophrenia", etc.
- Again- don't be afraid.
- Adults with disabilities are still adults. Do not treat them like children.
- Be Patient- we support people when they may be having the worst days of their lives.

Distressed In the Office

- Remain Calm and don't argue
- Keep your tone and pace steady.
- Use non-threatening stances
- Listen and be empathetic
- If children are distressed be "low and slow"
  - Low to the ground and slow moving
  - Low tone and slower speech

Distressed on the phone

- Stay on the phone- do not put on hold or transfer them.
- Get an address or location.
- Motion for a coworker to get help.
- Keep talking- be calm and listen
- MSW or RN should be contacted for help (refer to the eTool).
- If 911 needs to be called, the patient will remain talking to a staff member at the same time.

"Red Flags

- "I can't do this anymore!" "No one needs me!" Talking about dying, killing oneself.
- Self harming- cutting, burning, "scratching"
- Sounding "high" or intoxicated. Tell you they are intoxicated, especially if they plan to drive.
- Not making sense or "out of sorts".
- People may sound "frantic". Loud, scared.
- People say that they need help now or are afraid.

Valley Regional Healthcare

- The team continues to work on improving their data reporting and both the performance and operational metrics. Now with ample data in their registry from their CCSA implementation, the team has begun to produce a monthly dashboard of the data. Below are the statistics they have been reviewing from their registry. Aside from using this too internally to improve processes, the team is utilizing this data with external partners and presenting it at community forums.

ADULT PATIENTS				Q2: In your housing situation, do you have issues with any of the following?								Q3: Lack of transportation kept from medical appointments, meetings, work or getting things you need for daily living?	Q4: If somewhat hard or very hard, what do you have trouble paying for?							Q5: Felt unable to afford your medications?	Q6: Felt need to sell medications for food, housing, heat, etc?	Q8: Do you drink alcohol or use non-prescribed drugs? If no, skip CAGE	Q13: In the past 12 months, have you been threatened or scared by another person?	Q14: In the past 12 months, have you been forced to perform sexual acts?	Q15: Do you have legal issues that are getting in the way of your health or healthcare?	# of patients with PHQ-9 scoring 10 or higher	# of patients with GAD-7 scoring 10 or higher
Practice Total CCSA	Month	Does NOT qualify for the program (not in portal)	Q1: What is your housing situation today?	nonworking stove/oven	Bug Infestation	Mold	Lead Paint/Pipes	Water Leaks	Not enough hot water	No smoke detectors	Other		Food	Housing	Childcare	Health Need	Utility Bills	Debts	Other								
10	Jan-19	1	4	0	1	0	0	0	0	0	2	3	2	2	0	2	1	2	1	2	0	0	1	0	1	2	1
10	Feb-19	0	2	0	1	1	0	0	0	0	0	3	1	1	0	1	1	1	1	0	0	3	0	0	1	0	0
7	Mar-19	4	1	0	0	0	0	0	0	0	0	1	1	2	0	1	2	1	1	2	0	4	1	0	1	2	1
20	Apr-19	4	4	0	0	2	0	0	3	1	0	3	5	2	0	3	6	4	1	5	0	4	3	0	0	4	5
26	May-19	4	3	1	0	1	0	1	1	1	1	4	5	1	1	3	5	2	4	5	0	5	1	0	1	13	7
43	Jun-19	10	9	0	0	0	1	2	0	0	2	6	8	9	1	8	12	10	6	7	0	15	3	1	3	18	17
33	Jul-19	7	3	1	1	1	2	1	1	1	3	5	9	7	3	9	12	8	1	6	0	14	2	0	2	16	13
49	Aug-19	15	6	0	0	2	0	1	1	3	0	10	6	6	3	8	10	5	3	7	0	18	3	0	1	17	17
24	Sep-19	8	4	0	0	1	0	1	0	1	2	1	8	6	0	2	8	6	2	3	0	7	5	1	1	13	10
16	Oct-19	3	4	1	1	0	0	0	0	0	0	8	4	5	0	2	6	4	2	3	0	7	3	0	1	8	8
46	Nov-19	4	7	2	0	1	2	4	1	0	2	7	15	7	3	10	9	5	2	9	0	6	6	0	4	19	19
25	Dec-19	6	4	0	0	3	0	0	1	1	3	5	7	1	0	3	6	4	0	3	0	6	2	1	0	9	10
309	**TOTALS**	**66**	**51**	**5**	**4**	**12**	**5**	**10**	**8**	**8**	**15**	**56**	**71**	**49**	**11**	**52**	**78**	**52**	**24**	**52**	**0**	**89**	**30**	**3**	**16**	**121**	**108**
		21.4%	16.5%	1.6%	1.3%	3.9%	1.6%	3.2%	2.6%	2.6%	4.9%	18.1%	23.0%	15.9%	3.6%	16.8%	25.2%	16.8%	7.8%	16.8%	0.0%	28.8%	9.7%	1.0%	5.2%	39.2%	35.0%

YOUTH PATIENTS																		
Practice Total CCSA	Month	Does NOT qualify for the program (not in portal)	Q1: Drink alcohol? (more than few sips)	Q2: Smoke marijuana or hashish?	Q3: Use anything else to get high?	Do you smoke, chew, vape nicotine products?	Q1: Been in car driven by person high or had been drinking?	Q2: Use alcohol or drugs to relax, feel better about yourself, or fit in?	Q3: Use alcohol or drugs while you are by yourself or alone?	Q4: Forget things you did while using alcohol or drugs?	Q5: Family or friends ever tell you that you should cut down on your drinking or drug use?	Q6: In trouble while you were using drugs?	Q1: Felt depressed or sad most days, even if you felt okay sometimes?	Q2: In past month have had serious thoughts about ending your life?	Q3: Tried to kill yourself or made a suicide attempt?	# Patients with PHQ-9 scored 10 or higher	# Patients with GAD-7 scored 10 or higher
	Jan-19																
	Feb-19																
	Mar-19																
	Apr-19																
12	May-19	2	0	0	0	0	2	0	0	0	1	0	7	1	0	2	2
24	Jun-19	2	1	5	0	0	1	2	2	1	1	1	10	4	2	8	7
17	Jul-19	5	0	1	0	0	0	0	0	0	0	0	8	2	5	5	6
21	Aug-19	0	0	2	0	0	1	0	0	1	0	0	4	0	1	4	4
24	Sep-19	0	3	0	0	1	2	0	0	0	0	0	9	3	0	4	4
16	Oct-19	2	0	1	0	0	3	1	1	0	0	0	8	2	2	4	6
13	Nov-19	0	1	2	0	1	1	2	2	0	1	0	9	1	2	4	2
6	Dec-19	0	0	0	0	0	0	0	0	0	0	0	2	1	0	1	2
133	**TOTALS**	**11**	**5**	**11**	**0**	**2**	**10**	**5**	**5**	**2**	**3**	**1**	**57**	**14**	**12**	**32**	**33**
		8.3%	3.8%	8.3%	0.0%	1.5%	7.5%	3.8%	3.8%	1.5%	2.3%	0.8%	42.9%	10.5%	9.0%	24.1%	24.8%

Parents of Pediatric Patients					Q3: In your housing situation, do you have issues with any of the following?								Q4: Lack of transportation kept you or your child from medical appointments, meetings, work or getting things for daily living?	Q5: If somewhat hard or very hard, what do you have trouble paying for?												Q17: Struggle to provide:			Q19: During the past 2 weeks, has your child shown any of the following? (Score) 10+is CCSA positive
Practice Total CCSA	Month	Does NOT qualify for the program (not in portal)	Q1: What is your family's housing situation today? *Answers other than safe and secure*	Q2: Yes, my child live in more than one family home?	nonworking stove/oven	Bug Infestation	Mold	Lead Paint/Pipes	Water Leaks	Not enough hot water	No smoke detectors	Other		Food	Housing	Childcare	Health Need	Utility Bills	Debts	Other						Breakfast at Home	Fruit & Vegetables	Exercise & Physical Activity	
	Jan-19																												
	Feb-19																												
	Mar-19																												
	Apr-19																												
54	May-19	44	7	6	1	0	0	5	0	0	0	0	7	5	1	2	1	6	6	2	3	0	0	13	5	2	6	4	2
80	Jun-19	58	1	15	1	3	1	0	1	0	0	0	1	10	5	4	8	15	9	5	1	1	0	12	11	1	7	6	8
65	Jul-19	53	2	16	0	0	3	0	3	0	0	0	2	9	1	2	1	7	4	1	2	0	1	10	7	2	5	3	7
74	Aug-19	53	3	10	0	0	1	1	0	0	0	0	0	9	2	1	2	15	10	1	2	0	0	20	10	1	7	2	3
71	Sep-19	47	5	10	0	0	0	3	0	1	0	1	2	10	4	3	1	12	3	3	2	0	0	15	4	1	2	1	4
50	Oct-19	34	2	4	0	0	0	1	0	0	0	0	1	6	6	3	1	11	7	1	0	0	0	12	4	2	3	4	3
53	Nov-19	40	2	9	0	0	0	3	0	0	0	0	1	3	1	1	0	7	2	0	2	1	1	11	4	1	1	1	4
33	Dec-19	27	0	3	0	0	0	0	0	1	0	1	0	3	3	1	0	4	3	0	2	1	0	9	3	1	2	0	2
480	**TOTALS**	**356**	**22**	**73**	**2**	**3**	**5**	**13**	**4**	**2**	**0**	**2**	**14**	**55**	**23**	**17**	**14**	**77**	**44**	**13**	**14**	**3**	**2**	**102**	**48**	**11**	**33**	**21**	**33**
		74.2%	4.6%	15.2%	0.4%	0.4%	1.0%	2.7%	0.8%	0.4%	0.0%	0.4%	2.9%	11.5%	4.8%	3.5%	2.9%	16.0%	9.2%	2.7%	2.9%	0.6%	0.4%	21.3%	10.0%	2.3%	6.9%	4.4%	6.9%

- As the team looks towards the final year of supported implementation, they met at the end of the reporting period to discuss their focus. One primary focus is sustainability and looking to set up appropriate funding streams to support their two MSW positions and CHW position. Additionally, they want to continue to work on improving what they have implemented and become a truly integrated practice.
- 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,	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Project Y2 Q3 (Grant Q1 Y3) July 1, 2019 - September 30, 2019						
VRH	*Milestone 1* : Onboard New BHC	Onboarding Materials	Met	Met	Met	Met
	Milestone 2 : Complete SSA	SSA report	Met			
	Milestone 3 : Improve Data Processes	Notes	Met			
	Mileston 4 : PDSA CCSA Implementation	PDSA	Met			
Project Y2 Q4 (Grant Q2 Y3) October 1, 2019 - December 31, 2019						
VRH	*Milestone 1* : Utilization of SCP for all indicated high acuity patients	SCP Quarterly Data	Met	Met	Met	Met
	Milestone 2 : Adherence to CCSA response protocol	CCSA Quarterly Data	Met			
	Milestone 3 : MDCT meetings held monthly (at minimum)	Meeting Calendar	Met			
	Milestone 4 :Utilize Data and SSA to Improve Integration Efforts	Meeting Notes	Met			

MDCT/SCP

- VRH continues close partnerships with West Central Behavioral Health (WCBH) and Counseling Associates (CA), and has expanded their partnership with several others in the community to best address their patient needs. With expansion of partners and providers the team now meets twice a month for MDCTs to better accommodate the increase in patient cases and partners present at the table.
- All VRH sites are live of the CMT platform with SCPs being uploaded regularly by their behavioral health clinicians. Below is data about their MDCT meetings and SCPs for the past year, highlighting their growth and active involvement in the process.

MDCT Data 2019												
	January	February	March	April	May	June	July	August	September	October	November	December
Number of MDCTs Mtgs	1	1	1	2	1	1	1	1	1	1	2	2
Number of New SCPs	0	0	1	0	0	1	0	0	0	0	4	6
Number of Reoccurring SCPs	1	1	1	2	2	2	3	3	3	3	2	0
Number of External Partners	1	1	1	3	1	2	2	2	2	2	2	2
Number of closed SCPs	0	0	0	0	0	0	0	0	0	0	1	0
				x		x						

Timeline for Remaining Implementation

- As of June, 30th 2019, the team has met CCD requirements with the implementation of components spread across their primary care sites. The team is entered into improvement and maintenance phase over the past reporting period to ensure they processes and protocols they have set in placed are efficient and effective.
- Next steps for the team includes:
    - Continuing to improve CCSA and other screening rates
    - Increase number of SCPs and improve partnership coordination
    - Decrease ED utilization with the support of CMT data and improved training of the platform for ED staff
    - Utilizing registry date to promote population health

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

See appendix B1-2: CMC/MFS for updated Workplan (July-Dec, 2019)

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. This project will tackle bidirectional integration with embedded primary care services available at MFS for highest acuity patients. The project team began meeting in the summer of 2018. After hiring an APRN for the MFS clinic and finishing necessary environmental needs began seeing patient in April of 2019. Below are the objectives the team identified for the project.

- 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: July 1, 2019 – December 31, 2019

Project Workflows and Team Development

- The CMC/MFS team continued continues to meet bi-weekly, having changed their meeting times to Tuesday mornings following their bi-weekly MDCT meetings.
- The integration of the APRN into the CMHC clinic has being showing positive success with coordination of care in the organization. The challenge now is how to better interface with the primary care providers within Cheshire Medical Center. This has proven challenging as the APRN

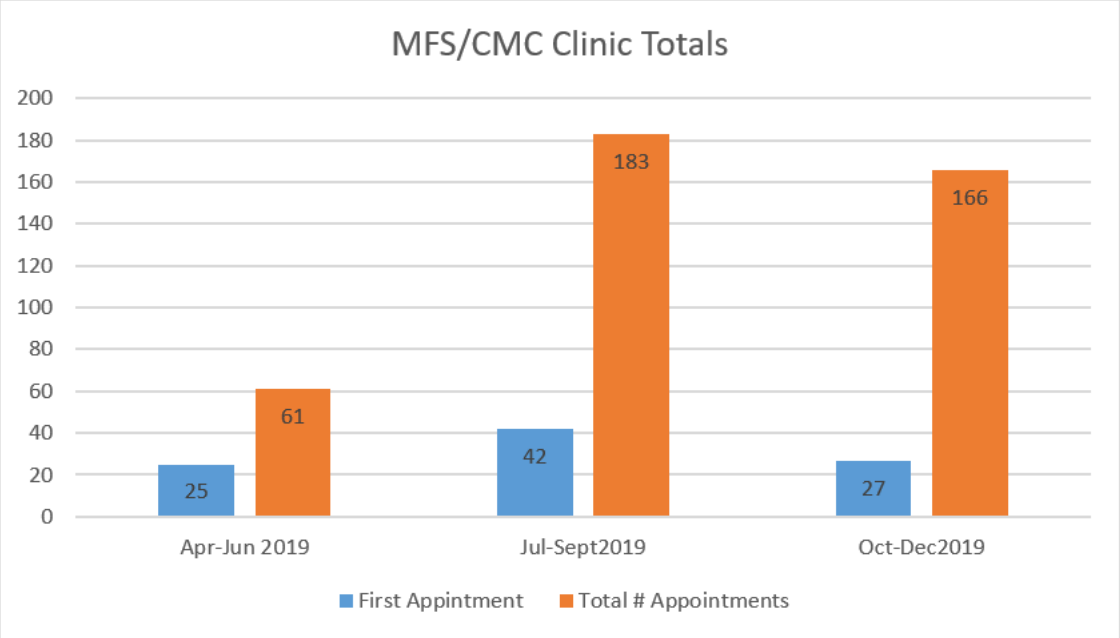
sits at the MFS clinic. The team plans to identify a work plan to better address this in the upcoming months.

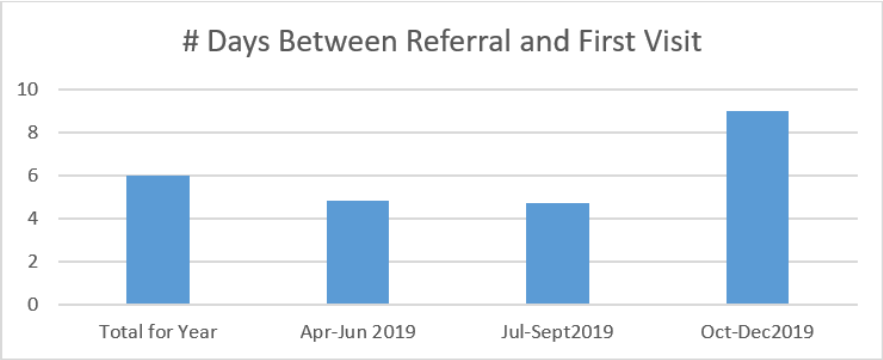
- The project team now consists of the APRN, MFS Program Officer, MFS Chief Medical Officer, CMC Integration Director, and CMC Nurse Manager, CMC Practice manager with sponsorship from MFS CEO, CMC Primary Care Medical Director and Vice President of Population Health.
- With the clinic well underway, the team has been looking at what metrics would be most valuable to use for improvement and sustainability. While they are still adjusting, below are current metrics bring used. Next steps are to look at other bi-directional models to determine if there are other metrics to be included in the dashboard. Once finalized the dashboard will be released more broadly on a monthly bases. Finally, the team will set goals for improvement and create a work plan for achieving those goals.

MFS/CMC Primary Care Services 2019

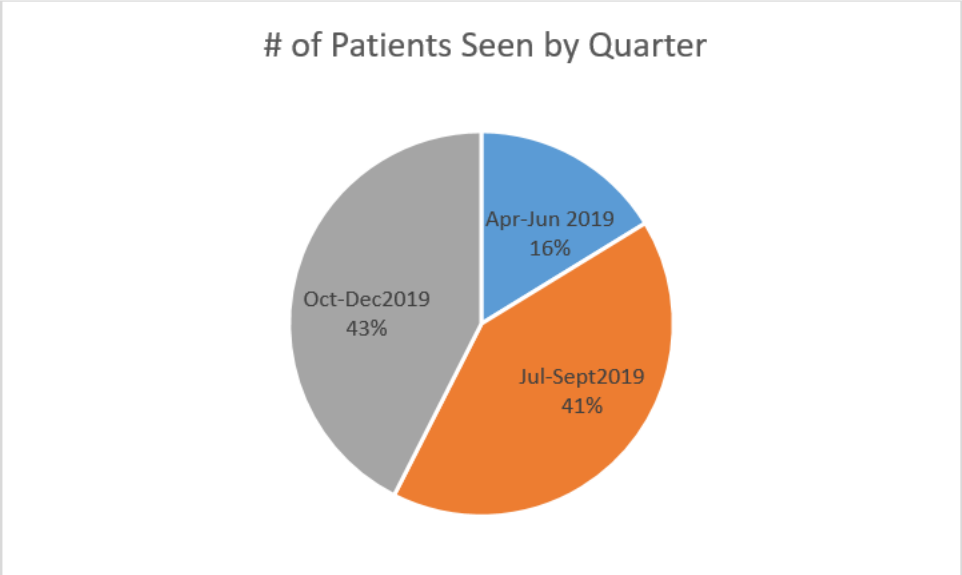
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Total
Ancillary Orders							1			1
Letter (Out)			1					2		3
Notes Only		3	2			1		3		9
Office Visit			23	48	55	78	81	79	67	431
Orders Only		3	3	6		6	3	6	4	31
Patient Message					3	2	2	4	5	16
Refill		1	8	13	11	14	28	25	48	148
Telephone	2	5	8	25	42	23	58	52	88	303
Unscheduled Encounter	2	26	8			2				38
Total	**4**	**38**	**53**	**92**	**111**	**126**	**173**	**171**	**212**	**980**

Total # of Unique Patients	102
Mean (Average # of visits)	4
Median (middle score)	3
Mode (most frequent # of visits)	1





	Total for Year	Apr-Jun 2019	Jul-Sept2019	Oct-Dec2019
# Days Between Referral and First Visit	6	5	5	9
Range	0-37	1-17	0-35	0-37



	Apr-Jun 2019	Jul-Sept2019	Oct-Dec2019
# of Patients Seen by Quarter	26	66	68

- The team has additionally been working on a patient satisfaction survey to distribute within the clinic as well as in a mail out. The purpose of this survey is to understand the quality, access and preventative implications of the program. The last draft of the survey can be viewed below. Additionally, the team will also be creating a staff satisfaction survey for those at MFS. This will look to measure joy in work, ease of access, effect on patient care and more.

Monadnock Family Services/Cheshire Medical Center Primary Care Clinic
Patient Satisfaction Survey

We would like to know how you feel about the services you received so we can make sure we are meeting your needs.
Your responses are directly responsible for improving these services. All responses are kept confidential and anonymous.

Please rate the following:		Excellent	Very Good	Good	Fair	Poor	Does Not Apply
Your appointment:	How easy was it to see Chris Polich?						
Your visit with Chris Polich:	How satisfied are you with the amount of time Chris Polich spent with you?						
	How satisfied are you with how Chris talked to you, listened to you and explained things?						
	How would you rate the overall care you received from Chris Polich?						
	If you did not see Chris, would you have:						
	Done nothing						
	Gone to the Walk-In/Urgent Care						
	Gone to the Emergency Room						
	Called your own PCP to get an appointment						
Our facility:	How convenient is the office location for seeing Chris Polich?						
Your overall satisfaction:	How likely are you to recommend Chris to other MFS consumers?						
	Overall, how would you rate your experience?						
Do you have suggestions for improving the services or space for the clinic?							
Do you have any additional comments?							

Thank you very much for your help!

- Finally, the team is focused on financial sustainability of the project. In the upcoming months the team will be reviewing resources on bi-direction models for billing support. Additionally, members of the team are working with the data/ it and revenue department to better understand what data and actions need to be in place to become financially independent. They will develop a business plan in the upcoming months.

MDCT/SCP

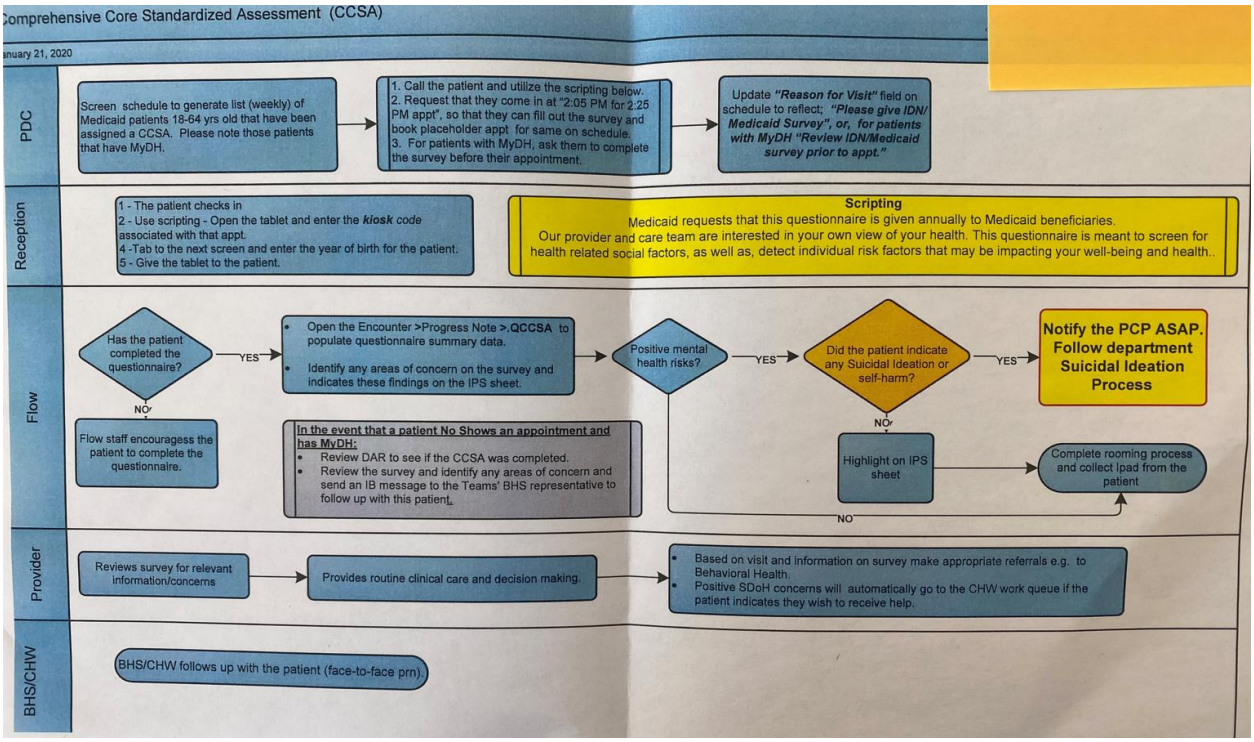
- In early fall 2019, the CMC/MFS implemented their first MDCT team. Working on a paper shared care plan while onboarding the CMT platform. The team identified a patient being seen by the project APRN and members of the ACT team at MFS. Over the course of the next few months, the team review this patient as they worked on flow, culture and facilitation of the meetings. They began adding additional patient towards the end of the reporting period.
- The team was able to onboard the CMT platform and uploaded their first share care plan in late fall of 2019.
- The team has focused on patient's being seen by the project APRN and MFS clients, while also ensure members of the CMC care team are at the table. Moving forward they will look to utilize the MDCT as an opportunity to transition patients to see more regularly their assigned primary care provider at CMC. Currently, there are patients who feel uncomfortable seeing their PCP at CMC due to stigma and other factors. As a result, the CMC team is working to offer additional stigma training to personnel.
- The emergency department at CMC has become an active member of the MDCT meetings. There has been a focus on many of the patients to develop a coordinated care approach for those who utilize the ED frequently and how they can support the patient in decrease preventable visits. The ED team is being trained on the CMT platform and accessing the shared care plans.

The team has been on track with meeting quarterly milestones, see below:

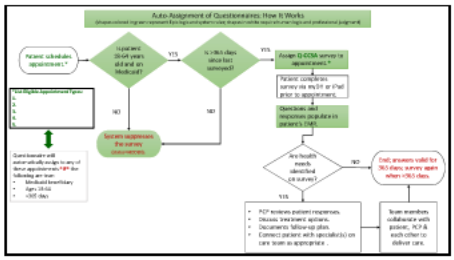
Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Y2 Q2: July 1, 2019 - September 30, 2019						
CMC, MFS	*Milestone 1*: Onboard CMT and conduct training	CMT contracts/ training schedule (Schedule Attached)	Met	Met	Met	Met
	Milestone 2: Identify Patients for MDCT	Criteria for identifying pts (Attached)	Met			
	Milestone 3: Develop MDCT Meeting Materials	Developed Materials (Attached)	Met			
	Milestone 4: bi-weekly meetings	Schedule (Attachment B)	Met			
Y2 Q3: October 1, 2019 - December 31, 2019						
CMC, MFS	*Milestone 1*: Onboard CMT and implement SCP	Data	Met	Met	Met	Met
	Milestone 2: Implement MDCT	Agenda	Met			
	Milestone 3: Collect and utilize data to Improve Integration Efforts	Meeting Notes/ Data	Met			
	Milestone 4: Document efforts of securing sustainable funding	Share Meeting Notes and developed/ updated materials	Met			

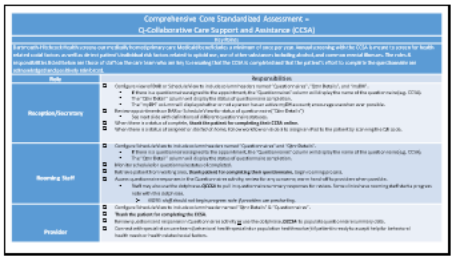
All Cheshire Primary Care B1 Implementation Progress:

- A project team focusing on the implementation and spread of the CCSA within the CMC primary care clinic has been meeting bi-weekly since the summer of 2019. The team consists of the nurse manage, practice manager, behavioral health clinician, medical assistant, receptionist, patient data coordinate, RN care coordinator and director of integration.
- The primary care team had implemented a paper version of the CCSA in the spring of 2019. The team has since purchased tablets and are now screening utilizing the Dartmouth system CCSA, planning to complete spread to Walpole and Winchester sites by the end of January. The project team has been diligently working on improving the process of the screening and follow-up as they rolled out to each additional primary care team. They receive training support from the DH Lebanon clinic in integrating the screener in the Epic interface. Below are the training and workflow.

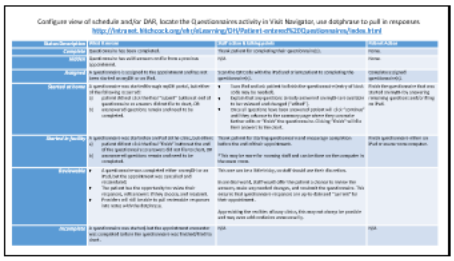

Comprehensive Core Standardized Assessment (CCSA)
January 21, 2020
PDC
Screen schedule to generate list (weekly) of Medicaid patients 18-64 yrs old that have been assigned a CCSA. Please note those patients that have MyDH.
1. Call the patient and utilize the scripting below.
2. Request that they come in at "2:05 PM for 2:25 PM appt", so that they can fill out the survey and book placeholder appt for same on schedule.
3. For patients with MyDH, ask them to complete the survey before their appointment.
Update "Reason for Visit" field on schedule to reflect; "Please give IDN/ Medicaid Survey", or, for patients with MyDH "Review IDN/Medicaid survey prior to appt."
Reception
1 - The patient checks in
2 - Use scripting - Open the tablet and enter the kiosk code associated with that appt.
4 -Tab to the next screen and enter the year of birth for the patient.
5 - Give the tablet to the patient.
Scripting
Medicaid requests that this questionnaire is given annually to Medicaid beneficiaries.
Our provider and care team are interested in your own view of your health. This questionnaire is meant to screen for health related social factors, as well as, detect individual risk factors that may be impacting your well-being and health..
Flow
Has the patient completed the questionnaire?
YES
NO
Flow staff encouragess the patient to complete the questionnaire.
Open the Encounter >Progress Note >.QCCSA to populate questionnaire summary data.
Identify any areas of concern on the survey and indicates these findings on the IPS sheet.
In the event that a patient No Shows an appointment and has MyDH:
Review DAR to see if the CCSA was completed.
Review the survey and identify any areas of concern and send an IB message to the Teams' BHS representative to follow up with this patient.
Positive mental health risks?
YES
NO
Did the patient indicate any Suicidal Ideation or self-harm?
YES
NO
Notify the PCP ASAP. Follow department Suicidal Ideation Process
Highlight on IPS sheet
Complete rooming process and collect Ipad from the patient
Provider
Reviews survey for relevant information/concerns
Provides routine clinical care and decision making.
Based on visit and information on survey make appropriate referrals e.g. to Behavioral Health.
Positive SDoH concerns will automatically go to the CHW work queue if the patient indicates they wish to receive help.
BHS/CHW
BHS/CHW follows up with the patient (face-to-face prn).

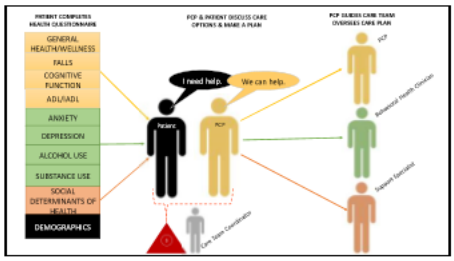
Automating the CCSA
Tips and Job Aids for Staff

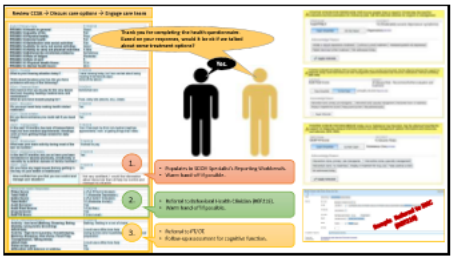

Auto-Assignment of Questionnaires: How It Works


Comprehensive Care Standardized Assessment –
Q-Collaborative Care Support and Assistance (CCSA)

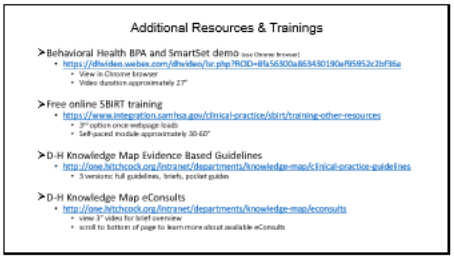
eDH
Tip and Trick
Welcome (Questionnaire) workflow v2018




PATIENT COMPLETES HEALTH QUESTIONNAIRE
PCP & PATIENT DISCUSS CARE OPTIONS & MAKE A PLAN
PCP GUIDES CARE TEAM OVERSEES CARE PLAN
GENERAL HEALTH/WELLNESS
FALLS
COGNITIVE FUNCTION
ADL/IADL
ANXIETY
DEPRESSION
ALCOHOL USE
SUBSTANCE USE
SOCIAL DETERMINANTS OF HEALTH
DEMOGRAPHICS
I need help.
We can help.
Patient
PCP
PCP
Behavioral Health Clinician
Care Team Coordinator
Support Specialist



myDH Support: Reset Password
Patients can call this number to have the password reset 603-354-5454 x 2446.
If a staff member is calling on patient's behalf, the patient will have to go through the reset process.
If the patient remembers their security question they can reset their password through the website by clicking on the 'I forgot my password' link.
Or they can send a message by clicking on the Technical Support link on the bottom of the myDH website.


Additional Resources & Trainings
➢Behavioral Health BPA and SmartSet demo
• https://dhwvideo.webex.com/dhwvideo/lsr.php?RID=4fa563000a863430190af95952c2bf36a
• View in Chrome browser
• Video duration approximately 27'
➢Free online SBIRT training
• https://www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources
• 3rd option once webpage loads
• Self-paced module approximately 30-60'
➢D-H Knowledge Map Evidence Based Guidelines
• http://one.hitchcock.org/intranet/departments/knowledge-map/clinical-practice-guidelines
• 3 versions: full guidelines, briefs, pocket guides
➢D-H Knowledge Map eConsults
• http://one.hitchcock.org/intranet/departments/knowledge-map/econsults
• view 1' video for brief overview
• scroll to bottom of page to learn more about available eConsults

- Over the course of the reporting period, the project team hired a behavioral health clinician and a community health worker to meet the needs of the increased screening. The positions were quickly on boarded and are actively addressing positive results. Additionally, will be onboarding a project manager and data coordinator to better support their progress efforts and ensure the implementation of a sustainable model.
- In the fall of 2019, the CMC team participated in their first site self-assessment. Below are the results of their first assessment.

Site Self-Assessment (SSA) Practice-Level Report

For IDN Region Number: 1 | And IDN Practice Number: 1-105

Average Scores: Domain One
Intergrated Services and Patient and Family Centeredness

	BL
1. Level of integration: primary care and mental/behavioral health care	5
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance a..	6
3. Treatment plan(s) for primary care and behavioral/mental health care	5
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	6
5. Patient/family involvement in care plan	5
6. Communication with patients about integrated care	5
7. Follow-Up of assessments, tests, treatment, referrals and other services	5
8. Social support (for patients to implement recommended treatment)	5
9. Linking to community resources	6

Average Scores: Domain Two
Practice/Organization

	BL
1. Organizational leadership for integrated care	7
2. Patient care team for implementing integrated care	4
3. Providers' engagement with integrated care ("buy-in")	5
4. Continuity of care between primary care and behavioral/mental health	6
5. Coordination of referrals and specialists	5
6. Data systems/patient records	5
7. Patient/family input to integration management	3
8. Physician, team and staff education and training for integrated care	4
9. Funding sources/resources	4

Composite Score Progression

Note:
BL - Baseline Assessment
F/U 1 - First Follow-Up Assessment
F/U 2 - Second Follow-Up Assessment
F/U 3 - Third Follow-Up Assessment

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Institute for Health Policy & Practice
Maine Health Access Foundation. Site Self-Assessment. Updated 2016
10/8/2019

- The team continues to meet all quarterly evaluation criteria. See 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
Y2 Q2: July 1, 2019 - September 30, 2019						
CMC	*Milestone 1* : Identify project team for implentation	Charter	Met	Met	Met	Met
	Milestone 2: Purchase and distribute tablets	Purchase receipt	Met			
	Milestone 3: Draft CCSA workflow for tablets	Workflow	Met			
	Milestone 4: bi-weekly meetings	Schedule	Met			
Y2 Q3: October 1, 2019 - December 31, 2019						
CMC	*Milestone 1* : Hire and Onboard BHC position	Job Description and Onboarding documents	Met	Met	Met	Met
	Milestone 2 : Hire and Onboard CHW position	Job Description and Onboarding documents	Met			
	Milestone 3 : Pilot CCSAs on Tablets	Pilot Schedule and PDSA information	Met			
	Milestone 4: Spread use of tablet CCSAs within clinic	PDSA on spread	Met			

Timeline for Remaining Implementation

- CMC has met full coordinated care team designation as of December 2019.
- Nest steps for both project teams include improvement, sustainability and further integration of the two teams.

B1 Newport Health Center (NHC) Coordinated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care)

See appendix B1-2: NHC for updated Workplan (July-Dec, 2019)

Project Overview

- The Newport Health Center Pediatrics team launched officially in early summer, 2018 with a small core team supported by the site MSW, Administrative support and Pediatrician.
- After meeting the coordinated care designation requirements for the pediatric practice, Newport Health Center completed the spread of to all adult providers in the summer of 2019.

Current State: January 1, 2019 – June 30th, 2019

Project Workflows and Team Development

- The project team, consistent of the LICSW, pediatric APRN, patient coordinator, nurse manager, CHW, project manager and Vice President of Population Health at New London Hospital. The team consistently met bi-monthly throughout the July to December reporting period, eventually moving from bi-monthly meetings to once monthly project team meetings.
- With the movement of providers between Newport Health Center and New London Hospital, the CCSA is as well being distributed in the New London Hospital primary care offices. In May of 2020 the New London Hospital/Newport Health Center system will be converting EHRs to the DHMC EPIC platform. This will allow for the implementation of the electronic DHMC CCSAs at both sites.
- After the implementation and spread of the CCSA across all providers, the team started to review their registry data for opportunities to improve. In addition, because the project manager contracted for the project also provides service to the VRH team, shared learning has benefitted the teams in their progress. Below is a dashboard the teams have reviewed to compare their data as well as NHC registry data. The two agencies are approximately 30 minutes from one another.

SAMPLE CCSA RESULTS OF TWO PROJECTS WITHIN REGION ONE (using same CCSA format)

ADULT PATIENTS ONLY	CCSA's Collected	Project #1	Project #2
	Jan-19	0	10
	Feb-19	0	10
	Mar-19	0	7
	Apr-19	0	20
	May-19	0	26
	Jun-19	14	43
	Jul-19	13	33
	Aug-19	5	49
	Sep-19	12	24
	Totals	**44**	**222**

CCSA's Collected	Project #1	Project #2
What is your housing situation today? *Any answer other than I have housing*	7	36
	15.91%	16.22%

CCSA's Collected	Project #1	Project #2
Do you drink alcohol or use nonprrescribed drugs?	22	70
	50.00%	31.53%

CCSA's Collected	Project #1	Project #2
Trouble paying for FOOD	16	45
	36.36%	20.27%
Trouble paying for UTILITIES	16	57
	36.36%	25.68%

CCSA's Collected	Project #1	Project #2
PHQ-9 scored 10 or higher	12	85
	27.27%	38.29%
GAD-7 scored 10 or higher	19	71
	43.18%	31.98%

Parents of Pediatric Patients	CCSA's Collected	Project #1	Project #2
	Jan-19	0	0
	Feb-19	2	0
	Mar-19	9	0
	Apr-19	8	0
	May-19	8	54
	Jun-19	3	80
	Jul-19	15	65
	Aug-19	9	74
	Sep-19	3	58
	Totals	**57**	**331**

CCSA's Collected	Project #1	Project #2
Struggle paying for FOOD	15	41
	26.32%	12.39%
Struggle paying for UTILITIES	21	55
	36.84%	16.62%

YOUTH PATIENTS	CCSA's Collected	Project #1	Project #2
	Jan-19	0	0
	Feb-19	2	0
	Mar-19	9	0
	Apr-19	13	0
	May-19	9	12
	Jun-19	0	24
	Jul-19	2	17
	Aug-19	8	21
	Sep-19	1	18
	Totals	**44**	**92**

CCSA's Collected	Project #1	Project #2
PHQ- scored 10 or higher	10	22
	22.73%	23.91%
GAD-7 scored 10 or higher	7	21
	15.91%	22.83%

CCSA's Collected	Project #1	Project #2
Felt depressed or sad most days even if you felt okay sometimes	16	36
	36.36%	39.13%

ADULT PATIENTS			Q2: In your housing situation, do you have issues with any								Q3: Lack of transportation kept from medical appointments, meetings, work or getting things you need for daily living?	Q4: If somewhat hard or very hard, what do you have													
Practice Total CCSA	Month	Q1: What is your housing situation today? *All but "I have housing"*	nonworking stove/oven	Bug Infestation	Mold	Lead Paint/Pipes	Water Leaks	Not enough hot water	No smoke detectors	Other		Food	Housing	Childcare	Health Need	Utility Bills	Debts	Other	Q5: Felt unable to afford your medications?	Q6: Felt need to sell medications for food, housing, heat, etc?	Q8: Do you drink alcohol or use non-prescribed drugs? **If no, skip CAGE**	Q14: In the past 12 months, have you been forced to perform sexual acts?	Q15: Do you have legal issues that are getting in the way of your health or healthcare?	# of patients with PHQ-9 scoring 10 or higher	# of patients with GAD-7 scoring 10 or higher
	Jan-19																								
	Feb-19																								
	Mar-19																								
	Apr-19																								
	May-19																								
14	Jun-19	3	0	1	3	0	3	0	0	0	2	6	0	0	1	6	4	1	1	0	8	0	0	1	7
13	Jul-19	2	0	0	1	0	1	0	0	0	2	5	2	0	1	2	1	2	1	0	5	0	0	3	3
5	Aug-19	1	0	0	0	0	0	0	0	0	1	1	2	1	1	2	1	0	1	0	3	0	0	2	3
12	Sep-19	1	0	0	0	0	0	1	1	0	2	4	3	1	1	6	3	1	1	0	6	0	0	6	6
32	Oct-19	4	0	1	1	0	0	0	0	1	2	9	3	2	0	9	9	2	2	0	13	0	0	11	6
41	Nov-19	4	2	0	0	0	2	1	0	0	6	6	4	3	2	11	8	3	0	0	20	0	1	16	8
37	Dec-19	4	0	0	0	0	3	1	1	2	6	11	3	2	7	7	7	4	4	0	21	0	0	9	5
154	**TOTALS**	**19**	**2**	**2**	**5**	**0**	**9**	**3**	**2**	**3**	**21**	**42**	**17**	**9**	**13**	**43**	**33**	**13**	**10**	**0**	**76**	**0**	**1**	**48**	**38**
		12.3%	1.3%	1.3%	3.2%	0.0%	5.8%	1.9%	1.3%	1.9%	13.6%	27.3%	11.0%	5.8%	8.4%	27.9%	21.4%	8.4%	6.5%	0.0%	49.4%	0.0%	0.6%	31.2%	24.7%

YOUTH PATIENTS		Q1: Drink alcohol? (more than few sips)	Q2: Smoke marijuana or hashish?	Q3: Use anything else to get high?	Do you smoke, chew, vape nicotine products?	Q1: Been in car driven by person high or had been drinking?	Q2: Use alcohol or drugs to relax, feel better about yourself, or fit in?	Q3: Use alcohol or drugs while you are by yourself or alone?	Q4: Forget things you did while using alcohol or drugs?	Q5: Family or friends ever tell you that you should cut down on your drinking or drug use?	Q6: In trouble while you were using drugs?	Q1: Felt depressed or sad most days, even if you felt okay sometimes?	Q2: In past month have had serious thoughts about ending your life?	Q3: Tried to kill yourself or made a suicide attempt?
Practice Total CCSA	**Month**													
0	Jan-19	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Feb-19	0	0	0	0	0	0	0	0	0	0	1	1	0
9	Mar-19	0	1	0	0	1	1	0	0	1	1	3	1	0
13	Apr-19	0	0	0	0	1	0	0	0	0	0	4	1	1
9	May-19	0	2	0	0	0	1	0	0	0	0	5	1	3
0	Jun-19	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Jul-19	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Aug-19	0	1	0	0	0	0	0	0	0	0	3	0	0
10	Sep-19	0	1	0	0	2	0	0	0	0	0	2	2	2
19	Oct-19	0	2	1	3	2	1	1	0	1	2	2	1	1
17	Nov-19	1	2	0	1	1	2	0	1	1	1	5	1	0
9	Dec-19	1	0	0	0	0	0	0	0	0	0	0	0	0
98	**TOTALS**	**2**	**8**	**1**	**4**	**5**	**4**	**1**	**1**	**2**	**3**	**17**	**5**	**6**
		2.0%	8.2%	1.0%	4.1%	5.1%	4.1%	1.0%	1.0%	2.0%	3.1%	17.3%	5.1%	6.1%

Parents of Pediatric Patients		Q1: What is your family's housing situation today? *Answers other than safe and secure*	Q2: Yes, my child live in more than one family home?	Q3: In your housing situation, do you have issues with any of the following?								Q4: Lack of transportation kept you or your child from medical appointments, meetings, work or getting things for daily living?	Q5: If somewhat hard or very hard, what do you have trouble paying for?							Q8: In the past 12 months, have you been threatened or scared by another person?	Q9: In the past 12 months, have you been forced to perform sexual acts?	Q10: Do you have legal issues that are getting in the way of your health or healthcare?	Q13: Does your child have an IEP or 504 plan in place at school?	Q14: Does your child receive counseling?	Q17: Struggle to provide:			Q19: During the past 2 weeks, has your child shown any of the following? (Score) 10+is CCSA positive
Practice Total CCSA	**Month**			**nonworking stove/oven**	**Bug Infestation**	**Mold**	**Lead Paint/Pipes**	**Water Leaks**	**Not enough hot water**	**No smoke detectors**	**Other**		**Food**	**Housing**	**Childcare**	**Health Need**	**Utility Bills**	**Debts**	**Other**						**Breakfast at Home**	**Fruit & Vegetables**	**Exercise & Physical Activity**	
	Jan-19																											
2	Feb-19	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
9	Mar-19	0	1	0	1	1	0	0	0	0	1	1	1	1	1	1	3	1	1	1	0	0	3	0	0	1	0	2
8	Apr-19	1	2	0	0	0	0	1	0	1	0	0	0	1	1	0	2	0	1	0	1	0	3	0	0	0	1	0
8	May-19	0	2	0	0	1	0	0	0	0	0	2	5	1	0	2	5	0	0	3	1	0	2	2	1	2	1	3
3	Jun-19	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2	1	1	0	0	0	0	0	1	1	1	0	1
15	Jul-19	0	0	0	0	0	0	0	0	0	0	0	5	3	2	0	5	3	1	2	3	0	8	8	4	3	2	1
9	Aug-19	0	0	0	0	0	0	1	0	0	0	1	2	1	0	0	3	0	1	3	2	0	3	2	0	1	0	2
3	Sep-19	0	1	0	0	0	1	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	3	1	1	0	0	0
10	Oct-19	0	1	0	0	1	0	1	0	1	0	0	1	0	0	0	1	0	0	0	1	0	5	4	0	1	0	1
6	Nov-19	0	2	0	1	0	0	0	0	0	0	0	2	1	0	1	2	1	0	1	1	0	3	2	1	1	2	0
3	Dec-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0
76	**TOTALS**	**1**	**9**	**0**	**2**	**3**	**1**	**4**	**0**	**2**	**1**	**5**	**18**	**9**	**4**	**6**	**24**	**6**	**4**	**10**	**9**	**0**	**31**	**21**	**8**	**10**	**6**	**10**
		1.3%	11.8%	0.0%	0.0%	3.9%	1.3%	5.3%	0.0%	2.6%	1.3%	6.6%	23.7%	11.8%	5.3%	7.9%	31.6%	7.9%	5.3%	13.2%	11.8%	0.0%	40.8%	27.6%	10.5%	13.2%	7.9%	13.2%

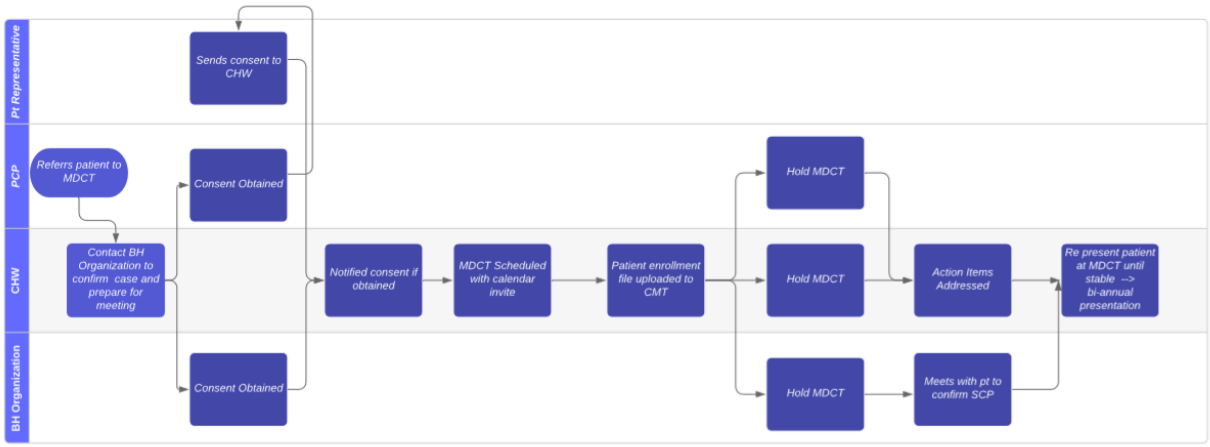
- The ongoing challenged for the project team is the proper support of middle management at the Newport Health Center. Engagement of the adult providers have not been fully achieved which has made improvement efforts difficult. Without the active participation of appropriate leaderships, the project team (primarily made up of pediatric personnel) will continue to be challenged in their improvements. The hospital system has onboarding a new CMO and will be onboarding a new CEO in the next couple of months whom has experience with a DSRIP Waiver in New York. We are hoping to better engage leadership to better support the adult providers understanding of the work.

- The team continues to meet all quarterly evaluation criteria. See 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
Y2 Q1: July 1, 2019 - September 30, 2019						
Newport Health Center	*Milestone 1* : Improve Adult CCSA Workflow	Process Map	Met	Met	Met	Met
	Milestone 2 : Improve CCSA Screening Rates	Data	Met			
	Milestone 3 : Determine Process and Protocol for MDCT SCP	Final Protocol/ Process	Met			
	Milestone 4 :Complete and Review SSA	SSA Report	Met			
Y2 Q2: October 1, 2019 - December 31, 2019						
Newport Health Center	*Milestone 1* : Improve CCSA Workflows	Supporting Documents	Met	Met	Met	Met
	Milestone 2 : Improve CCSA Screening Rates	Data/PDSA	Met			
	Milestone 3 : Improve/Add to MDCT Meetings	Supporting Documents	Met			
	Milestone 4 : MDCT mtgs Held Monthly	Schedule	Met			

MDCT/SCP:

- The team has continued to have monthly MDCT meetings with both West Central Behavioral Health and Counseling Associates. In the end of the reporting period, the team did onboard the CMT platform and was able to upload their first shared care plan. The team struggles around who best to own the coordination of the MDCT process. Through IDN administration support and that of the project manager we are working closely to better define their process and who should own what components of that process. Next steps after refining the process will include onboarding additional partners including the local school system. Below is the draft of the MDCT process.



Timeline for Remaining Implementation

- The team has met full spread of all CCD requirements by June, 2019.
- Focuses for the next reporting team include:
    - Improvement of current process
    - Review and analysis of data
    - Sustainability planning

B1 Monadnock Community Hospital (MCH) - Hospital Based Primary Care Practice Coordinated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care)

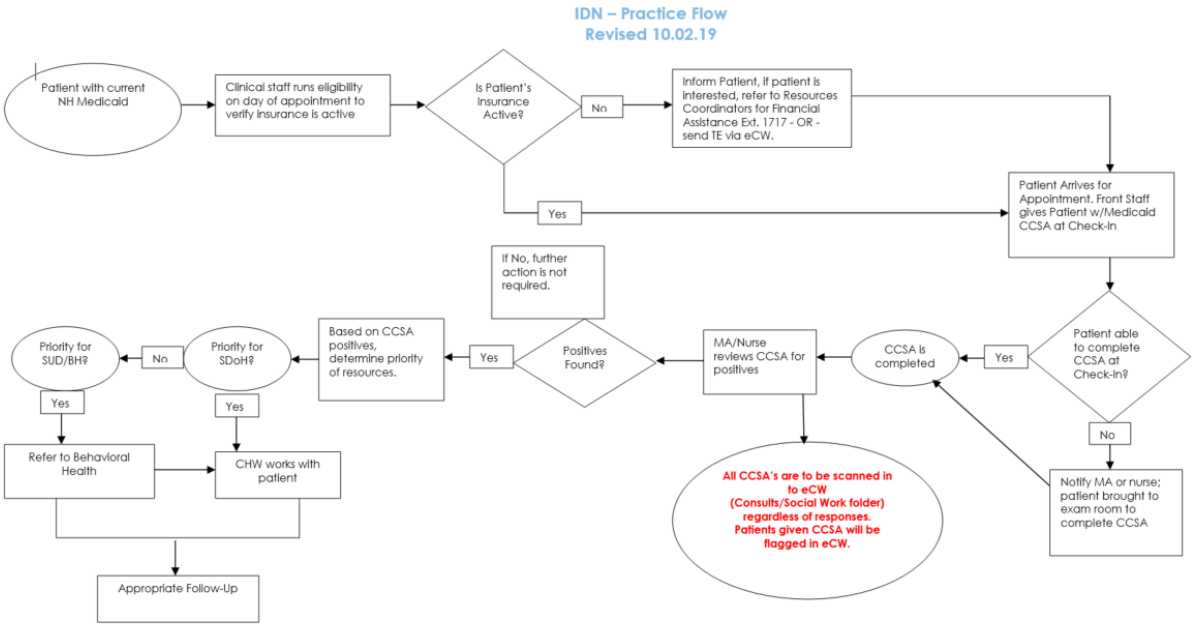
Project Overview

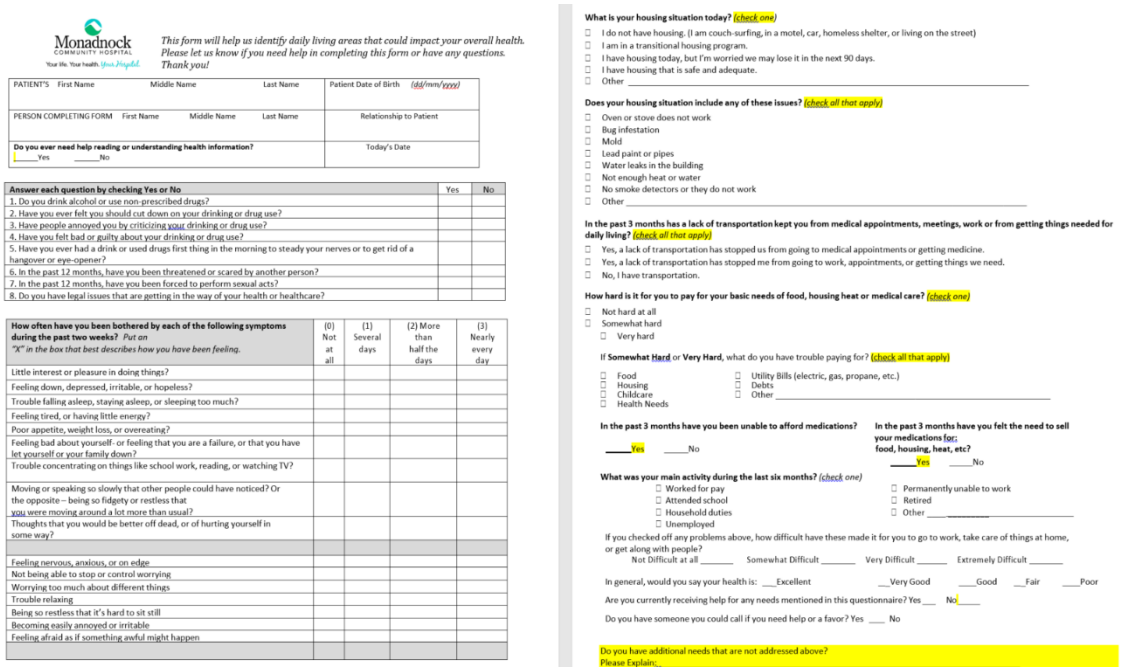
- The MCH project team began meeting in early summer, 2018. The team since early fall, 2018 has been meeting bi-weekly on Monday afternoons to work through and prep for project implementation.
- In early spring, the team experienced several leadership changes resulting in a stall of forward movement. In late spring the team reconvened under new leadership with the addition of primary care team staff from both implementation sites of Jaffrey and Ridge clinics. The team has since included a third satellite site, New Ipswich.
- The team has carried ongoing meeting bi-weekly meetings with the two teams which include physician champions, practice manager, MSW, project coordinator, medical assistance, receptionist and vice president of physician services.

Current State: July 1, 2019 – December 31, 2019

Project Workflows and Team Development

- Over the course of the reporting period, the project team met bi-weekly and was able to fully implement the CCSA across all three clinics: Jaffrey, Rindge and New Ipswich. The current state CCSA workflow can be seen below. The team also worked through many iterations of the CCSA, below is their latest draft.





Monadnock COMMUNITY HOSPITAL
Your life. Your health. Your Hospital.

This form will help us identify daily living areas that could impact your overall health. Please let us know if you need help in completing this form or have any questions. Thank you!

PATIENT'S First Name	Middle Name	Last Name	Patient Date of Birth (dd/mm/yyyy)
PERSON COMPLETING FORM First Name	Middle Name	Last Name	Relationship to Patient
Do you ever need help reading or understanding health information? ____Yes ____No			Today's Date

Answer each question by checking Yes or No	Yes	No
1. Do you drink alcohol or use non-prescribed drugs?		
2. Have you ever felt you should cut down on your drinking or drug use?		
3. Have people annoyed you by criticizing your drinking or drug use?		
4. Have you felt bad or guilty about your drinking or drug use?		
5. 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?		
6. In the past 12 months, have you been threatened or scared by another person?		
7. In the past 12 months, have you been forced to perform sexual acts?		
8. Do you have legal issues that are getting in the way of your health or healthcare?		

How often have you been bothered by each of the following symptoms during the past two weeks? *Put an "X" in the box that best describes how you have been feeling.*	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
Little interest or pleasure in doing things?				
Feeling down, depressed, irritable, or hopeless?				
Trouble falling asleep, staying asleep, or sleeping too much?				
Feeling tired, or having little energy?				
Poor appetite, weight loss, or overeating?				
Feeling bad about yourself- or feeling that you are a failure, or that you have let yourself or your family down?				
Trouble concentrating on things like school work, reading, or watching TV?				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

What is your housing situation today? *(check one)*

- ☐ I do not have housing. (I am couch-surfing, in a motel, car, homeless shelter, or living on the street)
- ☐ I am in a transitional housing program.
- ☐ I have housing today, but I'm worried we may lose it in the next 90 days.
- ☐ I have housing that is safe and adequate.
- ☐ Other _____

Does your housing situation include any of these issues? *(check all that apply)*

- ☐ Oven or stove does not work
- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Water leaks in the building
- ☐ Not enough heat or water
- ☐ No smoke detectors or they do not work
- ☐ Other _____

In the past 3 months has a lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? *(check all that apply)*

- ☐ Yes, a lack of transportation has stopped us from going to medical appointments or getting medicine.
- ☐ Yes, a lack of transportation has stopped me from going to work, appointments, or getting things we need.
- ☐ No, I have transportation.

How hard is it for you to pay for your basic needs of food, housing heat or medical care? *(check one)*

- ☐ Not hard at all
- ☐ Somewhat hard
- ☐ Very hard

If **Somewhat Hard** or **Very Hard**, what do you have trouble paying for? (check all that apply)

- ☐ Food
- ☐ Housing
- ☐ Childcare
- ☐ Health Needs
- ☐ Utility Bills (electric, gas, propane, etc.)
- ☐ Debts
- ☐ Other _____

In the past 3 months have you been unable to afford medications?

____Yes ____No

In the past 3 months have you felt the need to sell your medications for: food, housing, heat, etc?

____Yes ____No

What was your main activity during the last six months? *(check one)*

- ☐ Worked for pay
- ☐ Attended school
- ☐ Household duties
- ☐ Unemployed
- ☐ Permanently unable to work
- ☐ Retired
- ☐ Other _____

If you checked off any problems above, how difficult have these made it for you to go to work, take care of things at home, or get along with people?

Not Difficult at all _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult _____

In general, would you say your health is: ___Excellent ___Very Good ___Good ___Fair ___Poor

Are you currently receiving help for any needs mentioned in this questionnaire? Yes ___ No ____

Do you have someone you could call if you need help or a favor? Yes ___ No

Do you have additional needs that are not addressed above?
Please Explain:

- The team on boarded a new community health worker who has been working in each of the sites to address positive SDoH results, as well as maintain a registry of data. The position is new for the organization, so to support the patient's understanding of the role and how they can help they developed a flyer for patient education (see below).

Monadnock
COMMUNITY HOSPITAL
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COMMUNITY HEALTH WORKERS

Here to Help Support You!

Community Health Workers collaborate with your nurses and doctors to assist you with:

- HOUSING
- INSURANCE
- CHILD CARE
- FUEL ASSISTANCE
- TRANSPORTAION
- ACCESSING FOOD
- OTHER NEEDS IMPACTING YOUR WELLBEING

Your Community Health Worker, Margot Swanson, can meet with you before/after your medical appointment, at the hospital, or even in a location within your community. This is a free service!

Make an appointment with [redacted], MCH Community Health Worker.

Office:
Business Mobile: [redacted]

- Additionally, the team on boarded a duel position of licensed mental health counselor and masters licensed alcohol and drug counselor. This position is not only supporting positive screens but as well providing clinical ownership over the MDCT process.
- In late spring of 2019, the embedded behavioral health department underwent a staffing shortage having lost several of their behavioral health clinicians and psychiatric staff. They have since been able to rehire for all open positions providing additional resources to the external clinical sites.
- The team's provider champion has been an active part of the work, and with great interest in data improvement worked closely with the data/it to improve workflows between the two departments. The provider developed a grid to better address the measures with the team (below).

Measure	Do I have sheets showing how data is captured?/Do I need	Meeting Y/N	Next Steps
CSA (p7 of report)	Y	N	Just started
SUD screenings (p9)	Y	Y 49% last quarter	We are fine with this
Female intimate partner violence (P13)	Y	Y 93%	We are fine on this
TCM (p21)	Y (but need an explanation)	2018 we had good data 65% 2019 0 data so we fell down on report there	I think we just need to run the report that was done 2018 and we should be fine but I also think we are not looking in the right places for this
CLINICAL MEASURES			
Hypertension Screening (p 14)	N/N	Y 97%	We are fine on this
Hypertension Control (P19)	Y	? standard not set yet	We are probably ok here
Diabetes Care (Control) A1c <8 (p20)	Y	? target not set	We are probably ok here
Lipid Screening (p15)	Y	N	We need to discuss how we are capturing this because I know we are doing better than 4%
Adolescent Tobacco use and Prevention (P16)	Y	Y 77% (looks like we should have a star on this)	I think we are all set on this
Adult Tobacco Use Screening AND Counseling (p11)	Y	Goal is 40% we are at 38%	We are close and I think we can demonstrate we are doing better
Adult and Obesity Screening and Intervention (p17)	Y	1%???	Looks like we are not capturing right codes but I don't have info on what we are looking at
Child Obesity Screening and Intervention (p18)	Y	0%????	DITTO

- The team completed their third round of the site self-assessment in the fall of 2019. Interesting, the score dropped dramatically. This is due to the change in who was completing the assessments. The first two was completed by two high level administrators whose perspective on integration for the organization was much grander. The last round was completed by a larger more comprehensive team of front line staff (best practice). Completing the assessment was a good exercise for them to see opportunities of improvement and the importance of incorporating a variety of voices.

Site Self-Assessment (SSA) Practice-Level Report

For IDN Region Number: 1 | And IDN Practice Number: 1-110

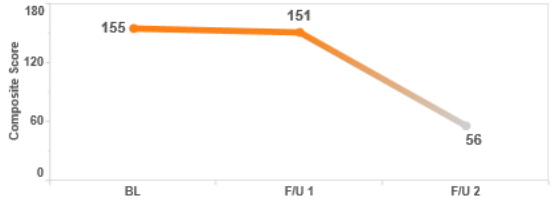
Average Scores: Domain One
Intergrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2
1. Level of integration: primary care and mental/behavioral health care	8	9	3
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance a..	8	9	4
3. Treatment plan(s) for primary care and behavioral/mental health care	8	9	2
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	8	7	5
5. Patient/family involvement in care plan	9	8	5
6. Communication with patients about integrated care	8	9	3
7. Follow-Up of assessments, tests, treatment, referrals and other services	9	8	6
8. Social support (for patients to implement recommended treatment)	9	9	4
9. Linking to community resources	10	9	2

Average Scores: Domain Two
Practice/Organization

	BL	F/U 1	F/U 2
1. Organizational leadership for integrated care	8	9	3
2. Patient care team for implementing integrated care	8	9	3
3. Providers' engagement with integrated care ("buy-in")	10	9	3
4. Continuity of care between primary care and behavioral/mental health	9	9	2
5. Coordination of referrals and specialists	9	9	3
6. Data systems/patient records	8	8	1
7. Patient/family input to integration management	8	7	3
8. Physician, team and staff education and training for integrated care	8	7	3
9. Funding sources/resources	10	7	1

Composite Score Progression



Note:
BL - Baseline Assessment
F/U 1 - First Follow-Up Assessment
F/U 2 - Second Follow-Up Assessment
F/U 3 - Third Follow-Up Assessment

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Institute for Health Policy & Practice
Maine Health Access Foundation. Site Self-Assessment. Updated 2016

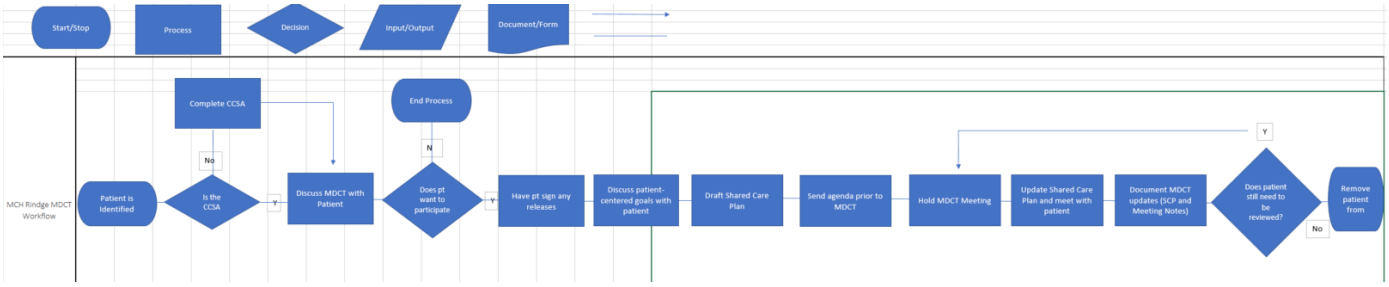
10/8/2019

- The team continues to make progress towards the quarterly evaluation milestones. See 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
Y2 Q1: July 1, 2019 - September 30, 2019						
Monadnock Community Hospital	*Milestone 1* : Finalize Standardized workflows and data collection for CCSA	Share Finalized Workflows and Deliverables	Met	Met	Met	Met
	Milestone 2: Pilot Practices CCSA Launch for Elgible Members	Data	Met			
	Milestone 3: Onboard CHW	Onboarding documents	Met			
	Milestone 4: Finalize Standardized Workflows and Protocols for MDCT	Share Finalized Workflows and Protocols	Met			
Y2 Q2: October 1, 2019 - December 31, 2019						
Monadnock Community Hospital	*Milestone 1* : Train Staff for Spread of CCSA	Training Documents	Met	Met	Met	Met
	Milestone 2: Spread CCSA implementation past pilot teams	Notes	Met			
	Milestone 3:Onboard CMT Platform	Use of SCP	Met			
	Milestone 4: Conduct MDCT Meeting	Share Mtg Notes	Met			

MDCT/SCP

- Over the course of the reporting period, the project team conducted their first MDCT with SCP uploaded to CMT at the end of the year. The team worked diligently over the term to finalize workflows, agendas, updated protocols from other IDN 1 sites and identifying an appropriate patient. Given the unique structure of MCH having behavioral health embedded within the systems, they were able to hold the meeting internally. Future plans include expanding number of patients presented, representation from the ED with proper training of CMT, working with outside agencies for shared patients. Below are the updated MDCT documents.



MCH - MULTIDISCIPLINARY CARE TEAM MEETING

Sample Agenda

Date: Monday, November 1, 2018

Place: MCH/Conference Rooms 1 & 2

Facilitator: Amy Reynelli, MLADAC LCMHC

Meeting Coordinator: Louise Danforth

1. New Patients with Shared Care Plans
   a. Jane Doe
   b. John Smith

2. Review of Existing Shared Care Plans
   c. Jane Doe
      i. Update from Dr. Cooley
      ii. Update from MBHS
      iii. Positive Outcomes?
      iv. Challenges?
      v. Plan?

   d. John Smith
      i. Updates from Dr. Cooley
      ii. Updates from MBHS
      iii. Positive Outcomes?
      iv. Challenges?
      v. Plan?

3. Upcoming MBHS Discharges?

4. Additional updates for patients in need of follow-up and closure of files?

IDN Region-1 Primary Care & Behavioral Health Integration Pilot
Monadnock Community Hospital

Multidisciplinary Care Team Protocol

PURPOSE
To provide effective and efficient collaboration of treatment and care for Medicaid patients/clients, identified with both complex needs and behavioral health needs.

TEAM MEMBERS
The Multidisciplinary Care Team (MDCT) will consist of staff from the primary care practice(s) at Monadnock Community Hospital including primary care and Monadnock Behavioral Health Services. Staff from MCH may include a CHW, MLADAC, Psychiatrist, and a primary care provider. During phase one, adult Medicaid patients of Dr. Elizabeth Cooley, provider at Monadnock Community Hospital, will participate in the MDCT pilot.

ROLES
Facilitator: [?] will serve as the facilitator of initial MDCT meeting. Subsequent meetings will be facilitated by team members. [?] will create the monthly agenda, coordinate meeting locations, and send out electronic invitations.

Project Coordinator: The IDN Project Coordinator will document discussions of team members, progress, barriers, and treatment plans for each patient discussed, as well as keep time.

Participants: All Team members will be equal participants in the MDCT meetings.

COMMUNICATION OF PRIVATE HEALTH INFORMATION
Prior to communication of a patient's private health information between partner agencies, a release of information form will be signed by the patient. This form will be scanned into the MCH patient record and an electronic copy will be sent via encrypted email to the partnering behavioral health agency.

Following receipt of the signed release form, MDCT members will collaborate on the patient case through phone, fax, in-person communication, and encrypted electronic messaging.

MDCT MEETING FORMAT & LOGISTICS
1) Before each MDCT meeting, the agenda and draft Shared Care Plan (SCP) for new patients will be electronically distributed through encryption to all MDCT group members.
2) The SCP will guide the discussion of each patient's case. *See Shared Care Plan Protocol for information specific to these plans.*
3) The agenda will include the following:
   A. New Patients: draft SCP and BH staff share results of initial assessment; treatment recommendations will be made by team members and proposed modifications to the draft plan will be noted.
   B. Existing SCP: updates, progress and barriers, as well as proposed potential supports to address identified barriers by all team members.
   C. Anticipated Behavioral Health Discharges within the next 1-2 months: Have the goals been met? If so, what are the next steps? If not, what were the barriers, and what support or services might help the patient/client reach their goals? What support and/or plans are in place to keep the patient stabilized?
4) MDCT meetings will remain focused on the needs of the identified patients and not a place to discuss programming or systems-level needs.
5) MDCT meetings will meet once a month. Date and time are yet to be determined.
6) MCH will host this meeting and alert behavioral health agency(ies) of the location through a calendar invitation and/or email.

WRITTEN MATERIAL
All written material, including meeting agendas, Shared Care Plans, signed MDCT release forms, and meeting minutes will be stored in a secure electronic folder within the MCH system. Only MCH direct treatment team members will have access to the electronic file. Final Drafts of SCPs and MDCT release forms will be scanned into the patient clinical records. The SCP will be available under the [?] heading and the release form will be available under the Consent Form heading within the electronic health record at MCH.

At the conclusion of each meeting, the [?] will transcribe updates and recommendations made by the MDCT into each MCH patient chart specifically utilizing the meeting minutes. This will allow the extended MCH treatment team to effectively support the patients in reaching their treatment goals.

IDN Region-1 Primary Care & Behavioral Health Integration Pilot
Monadnock Community Hospital (MCH)

SHARED CARE PLAN PROTOCOL

DEFINITIONS
CCSA *–Comprehensive Care Standardized Care Assessment framework (aka: patient questionnaire) that includes evidence-based universal screening questions (PHQ-9, GAD-7) designed to identify positive social determinants of health needs, including domains for substance use, housing, family, education, employment, personal safety, legal, depression and suicide risk.*

MDCT – *Multi-disciplinary Care Team consists of providers from primary care, behavioral health, and social services practices to support patients at risk for or with diagnosed behavioral health conditions or chronic conditions.*

SCP – *The Shared Care Plan, which will initially be a summary document and eventually web-based support, is designed to capture patient goals and information critical to diagnosis, treatment, and management of care.*

IDENTIFICATION OF PATIENTS
The [?] will generate a report indicating which patients, within an identified population, are high utilizers of the MCH Emergency Department. Phase one of the pilot program will focus on adult (18 yrs. old and over) Medicaid or Medicaid-eligible patients of Dr. Elizabeth Cooley. The [?] will review the dates of emergency department services to identify if services were rendered related to a resolved, special circumstance, or if they are current and/or ongoing. For those falling into the latter category, the [?] will review patient files to identify if any behavioral diagnosis is present. For those fitting into these categories, a SCP may be appropriate.

Once a patient is identified as potentially needing a SCP level of support, the [?] will discuss the patient's case with the primary care provider. In the pilot program, this will be Dr. Elizabeth Cooley. If Dr. Cooley agrees with the [?] regarding patient need, the [?] will contact the patient to schedule an appointment.

CCSA UTILIZATION AND TRANSITION TO THE SCP
At the intake of the initial [?] assessment appointment, the patient will be asked to complete a CCSA form. This will help the [?] to identify areas of potential concern related to social determinants of health, depression symptoms, anxiety symptoms and substance use. The [?] and patient will discuss the results of this screening tool and discuss a potential referral to behavioral health services. If these services are desired by patient, the [?] will make a referral and will work with the patient to

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create an initial SCP based on patient need and preference. For the pilot of this program, Monadnock Behavioral Health Services will be the behavioral health agency partnering with MCH on cases involving a SCP.

ELEMENTS OF THE SHARED CARE PLAN
"Concerns" could be concerns from either the patient or care-team member that may require attention, intervention or support, including the topics of literacy/communication, food insecurity, housing, legal, insurance, substance issues, transportation, DV/sexual abuse, mental health, employment and financial.

"Person Centered Goals" documents the patient-defined outcomes or conditions they would like to achieve, such as comfort, stability, interventions, lessening of health concerns, etc.

"The Plan" is created by the care team, incorporates the patient-centered goals and concerns, and outlines future actions.

"Other" will capture any relevant information to the patient that does not fall into previous categories.

SCP PROCEDURE
Once a SCP draft is completed, the [?] will present the SCP and patient case at the next Multidisciplinary Care Team (MDCT) meeting. Behavioral health staff will have completed their initial evaluation process with the patient and will have a copy of the draft SCP from MCH. Members of the MDCT will discuss the SCP as well as the treatment recommendations made by the clinical staff from the mental health agency. MDCT team members will either agree with the SCP draft as it is written or will propose modifications.

The [?] will meet with the patient, following the MDCT meeting, to discuss the outcome of the meeting. If no modifications to the plan were proposed, treatment providers will move forward with supporting the patient in reaching identified and documented goals. If modifications are suggested, the [?] will review these proposed changes with the patient and connect with the behavioral health provider directly to discuss patient wishes.

Once a SCP has been agreed upon, members of the MDCT will determine who will provide what services or support to help the patient reach his/her goals. Team members will discuss progress during MDCT meetings and problem solve around any barriers or challenges that are present during treatment.

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GOAL COMPLETION & CONCLUSION OF SERVICES
During treatment, the [?] will monitor patient's level of stability related to each social determinant of health (SDoH) that was marked in the SCP. The level of stability will be based on changes in the results of CCSA, PHQ-9 and GAD-7 results and informed by the Self-Sufficiency Matrix assessment tool. When the identified goal is met, team members will discuss the patient's level of need during the MDCT meeting. If the goal is met, but the SDoH(s) remain unstable, the team members will discuss if behavioral health supports continue to be needed and, if so, a new SCP should be drafted with the patient. If mental health supports are no longer indicated, but SDoH remain unstable, team members will draft discharge plan recommendations to be discussed with the patient. Following discharge from behavioral health services, the [?] will continue to monitor and support patient's progress in addressing identified needs as he/she utilizes community resources.

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Monadnock
COMMUNITY HOSPITAL
Your life. Your health. Your Hospital.

Shared Care Plan Script for Provider:

- I would like to talk with you about your Shared Care Plan, which is a treatment plan to help identify your goals and different ways we can help support you.
- The Shared Care Plan is a plan developed with you, your primary care team, your behavioral health providers, and your community support team (***show patient a sample SCP***).
- This is a nationwide electronic system, which allows your past, present, and future treating Providers to view your care plan and assists Providers from different agencies to focus on your identified goals (Providers may be medical staff at an ED, hospital, or other healthcare agency).
- I will check in with you to make sure your health/behavioral health goals are up to date on the SCP 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.
- At any time you may request *in writing*, who has viewed your Shared Care Plan.
- If you agree to sign this form, you will be giving Monadnock Community Hospital permission to share your sensitive information that is in your Shared Care Plan.
- You are not required to sign this form if you can choose to opt out of this program. It will not change your ability to receive treatment from Monadnock Community Hospital.
- You can change your mind at any time, please let us know in writing, and we will stop sharing your information moving forward. We cannot take back information that was disclosed before this written change was made.
- What questions do you have about this consent form or anything else we discussed so far?

IF APPLICABLE: We do need your separate written permission for sharing information pertaining to your Substance Use Disorder (SUD) treatment plan. This information requires a separate consent to use on your electronic Shared Care Plan.

DRAFT

Timeline for Remaining Implementation

- As of December 2019 MDCH has met both coordinated care and integrated care designation. The organization had the capacity to offer MAT services and are working with other grant agencies to build a more robust program.
- Next steps for the organization are focusing on improving their implementation efforts, sustainability and on boarding additional external partnerships.

B1 Alice Peck Day Memorial Hospital Primary Care Coordinated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care)

See appendix B1-2: APD for updated Workplan (July - Dec, 2019)

Project Overview

- The team began meeting bi-weekly in the early fall of 2018.
- In May of 2019 the APD team underwent a system wide EHR conversion, onboarding to the DHMC Epic platform. Progress on their work to implement the CCSA and other CCD components were slow until they were able to go through the event.
- The team proposed to follow the AIMS center collaborative care model and after careful consideration moved to adoption of the full DH CCSA in EPIC in June, 2019

Current State: July 1, 2019 – December 31, 2019

Project Workflows and Team Development

- After the pilot implementation of the CCSA in June of 2019, the project team worked diligently to spread the screener across all of their primary care providers, completing their spread in August. The team has since conducted multiple PDSAs to help ensure a more efficient and effective process. The behavioral health clinician and community health worker have been working closely together to address the CCSA positives. Recently, they have been active in the data reporting portal to QA the data and look at opportunities for improving "fails".
- Over the reporting period the team had decreased to once monthly meetings and have taken over the project management aspects of the work. The IDN program manager and medical director continue to attend the meetings in a consultation capacity.
- In the fall of 2019 the team completed their third site-self assessment having increased their overall score by 33 points. The team is feeling more confident about their level of integration and plan to continue to improve utilizing the collaborative care model.

Site Self-Assessment (SSA) Practice-Level Report

For IDN Region Number: 1 | And IDN Practice Number: 1-100

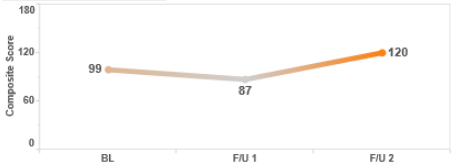
Average Scores: Domain One
Intergrated Services and Patient and Family Centeredness

	BL	F/U 1	F/U 2
1. Level of integration: primary care and mental/behavioral health care	4	4	7
2. Screening and assessment for emotional/behavioral health needs (e.g. stress, depression, anxiety, substance a...	4	5	7
3. Treatment plan(s) for primary care and behavioral/mental health care	4	3	7
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	5	5	6
5. Patient/family involvement in care plan	8	5	7
6. Communication with patients about integrated care	3	4	7
7. Follow-Up of assessments, tests, treatment, referrals and other services	6	5	7
8. Social support (for patients to implement recommended treatment)	5	5	8
9. Linking to community resources	5	5	7

Average Scores: Domain Two
Practice/Organization

	BL	F/U 1	F/U 2
1. Organizational leadership for integrated care	8	7	8
2. Patient care team for implementing integrated care	7	5	7
3. Providers' engagement with integrated care ("buy-in")	7	5	8
4. Continuity of care between primary care and behavioral/mental health	4	5	7
5. Coordination of referrals and specialists	6	5	6
6. Data systems/patient records	5	6	6
7. Patient/family input to integration management	5	4	4
8. Physician, team and staff education and training for integrated care	7	4	5
9. Funding sources/resources	6	5	6

Composite Score Progression



Note:
BL - Baseline Assessment
F/U 1 - First Follow-Up Assessment
F/U 2 - Second Follow-Up Assessment
F/U 3 - Third Follow-Up Assessment

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Institute for Health Policy & Practice
Maine Health Access Foundation. Site Self-Assessment. Updated 2016

10/8/2019

- The team is hoping to onboard tele psychiatry in the upcoming months. Looking to improve their partnership with DHMC-Lebanon to provide these services in a more integrated way for their patients. The ongoing challenge is the workforce shortage in the area for these services. Leaders from both organizations are meeting to further address the implementation.

  - The team continues to meet all quarterly evaluation criteria. See 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
Y2 Q1: July 1, 2019 - September 30, 2019						
Alice Peck Day Memorial Hospital	*Milestone 1*: Provide Training to Clinical Staff on IDN Components	Training materials	Met			
	Milestone 2: Onboard CMT platform and document SCP	Notes	Met			
	Milestone 3: Complete SSA and Review Results	SSA results	Met			
	Milestone 4: Spread CCSA process to additional partners	Data	Met	Met	Met	Met
Y2 Q2: October 1, 2019 - December 31, 2019						
Alice Peck Day Memorial Hospital	*Milestone 1*: Complete Spread of CCSA	Data	Met			
	Milestone 2: Develop workplan for improvement and sustainability	Workplan	Met			
	Milestone 3: PDSA CCSA screening rates	PDSA	Met			
	Milestone 4: Increase MDCT patients discussed and complete SCP	Data	Met	Met	Met	Met

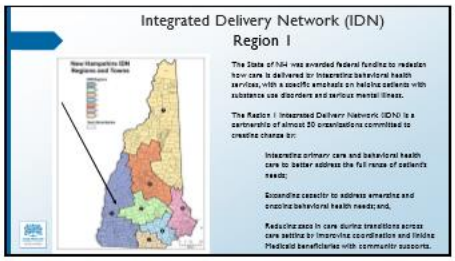
MDCT/SCP

- The APD team has been holding MDCT meeting since June of 2019. The team has on boarded the shared care plan tool within CMT and has had several positive experience in using the platform. They had patients appear at two different emergency departments in the region in which they were provided an event notification.
- The team has been tracking progress of improvement for the MDCT in presenting cases and capturing shared care plans. They will be utilizing the tracking mechanism to collect data for improvement purposes.

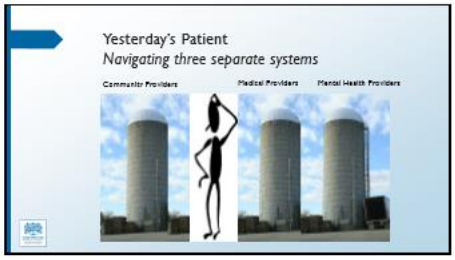
MDCT Data 2019	January	February	March	April	May	June	July	August	September	October	November	December
Number of MDCTs Mtgs						1	1	1	1	1	0	1
Number of Abbreviated MDCTs						4	4	4	4	4	4	3
Number of New SCPs						1						2
Number of Reoccuring SCPs											1	1
Number of External Partners						2	3	3	3	3	4	4
Number of closed SCPs						0	0	0	0	0	0	0
Number of Active SCPs						1	1	1	1	1	1	3
Onboarding of External Partners (please indicate with an X when external partner first joined an MDCT)												
WCBH						X						
Twinpines									X			
Headrest						X						
Counseling Associates											X	

- As the team worked to improve their process and increase case presentations, the team provided a training to the primary care staff to better improve referrals. Below is the presentation they provided.

IDN, CCSA, MDCT

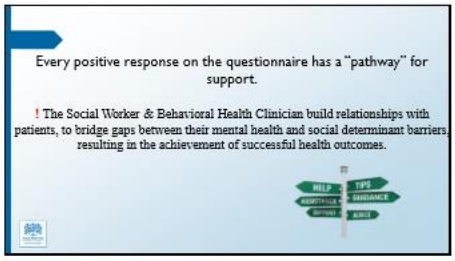

Integrated Delivery Network (IDN)
Region I
The State of NH was awarded federal funding to redesign how care is delivered by integrating behavioral health services, with a specific emphasis on helping patients with substance use disorders and serious mental illness.
The Region I Integrated Delivery Network (IDN) is a partnership of almost 50 organizations committed to creating change by:
Integrating primary care and behavioral health care to better address the full range of patient's needs;
Expanding capacity to address emerging and ongoing behavioral health needs; and,
Reducing gaps in care during transitions across care settings by improving coordination and linking Medicaid beneficiaries with community supports.

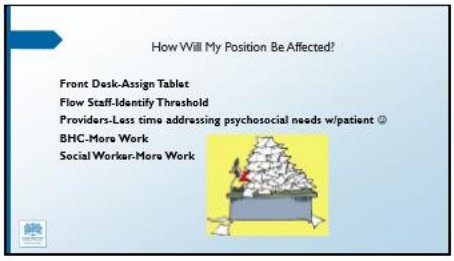
Behavioral Health Partners
Counseling Associates
West Central Behavioral Health
More to come..

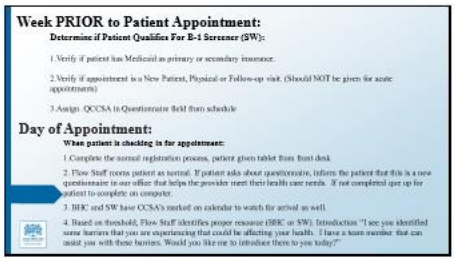

Yesterday's Patient
Navigating three separate systems
Community Providers
Medical Providers
Mental Health Providers

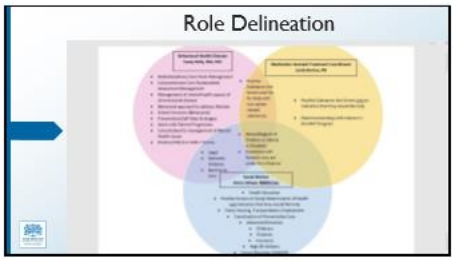
Reimagining Patient Care through the lens of Integration
Innovation and collaborative relationships with behavioral health providers and community partners established and thriving for bi-directional approach to care
Efficient procedures and workflows created to empower staff and serve patients successfully
Embracing a multi-faceted approach to mental health and primary care integration and removing the stigma by normalizing behavioral health
COMMUNITY SUPPORT

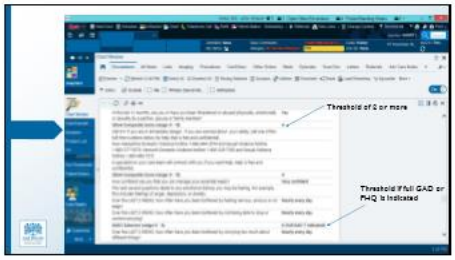
How Does This Improve Patient Care?
!Screens patients for social, emotional & behavioral health needs
!Identifies potential challenges impacting health
! Opens conversation between social worker/BHC and patient on areas of concern and desired supports

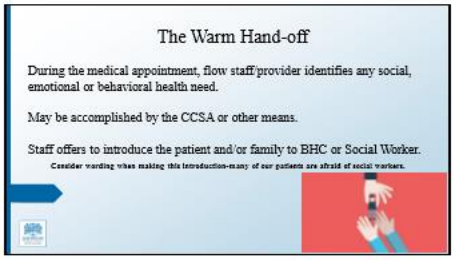












Timeline for Remaining Implementation

- The team has met CCD requirements spread as of August 2019 as well as integrated care having the capacity to offer MAT services to patients. Next steps include improvement of implementation efforts, sustainability for integrated care model, and improve partner relationships.

B1 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 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 having ongoing conversations in how the organizations can support the B1 teams in the region. 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 and will be onboarding them to the MDCT meetings in the next few months. The organization underwent leadership changes in the past

year, which slowed progress. The IDN leadership continues to have conversations to support on boarding CMT platform.

Counseling Associates (CA)

Counseling Associates begun their B1 support with a contractual relationship with VRH. With the growth of the region and need for behavioral health access, the IDN administration restructure contracts to directly fund counseling associates for B1 support to multiple primary care agencies, therefore removing them as a subcontractor of VRH. The IDN now holds a support contract directly with Counseling Associates running through 12/31/20. Counseling associates is now actively involved with Valley Region Hospital, New port Health Center, Alice Peck Day and soon will be on boarding with Dartmouth Hitchcock Lebanon Teams. The organization has been actively deploying the CCSA for a couple of years. Counseling Associate staff have also been active members of the E5 Sullivan County Complex Care team having presented several de-identified cases.

West Central Behavioral Health (WCBH)

West Central Behavioral Health originally started their work in partnership with the DHMC Heater Rd. team. Similar to CA's expansion of services, WCBH quickly began partnerships with other B1 teams to better support the coordination of care and access with behavioral health services. As result, WCBH became another B1 supporting contract receiving funding for increase capacity to serve the B1 teams. WCBH now sits at the MDCT tables for Valley Regional Hospital, Newport Health Center, Alice Peck Day and all three Dartmouth Hitchcock teams. WCBH has met the requirements for distributing the CCSA for a couple of years. Staff of WCBH have also been a regular member of the E5 Sullivan County Complex Care Team, having presented several de-identified cases. Additionally, WCBH leadership are an active part of the steering committee for the expansion of the E5 work.

Monadnock Family Services (MFS)

Monadnock Family services has been an active participant of the bi-direction B1 project in which a CMC APRN is embedded in their clinic to provide medical services to their patients. In addition, they are provided a B1 support contract in order to build capacity in meeting the behavioral health needs of the area. While they have closely partnered with CMC and other social service agencies, they are hoping to improve their relationship with Monadnock Community Hospital in the upcoming year. MFS has implemented the CCSA required screen for a couple of years.

Headrest

Headrest has been an active participant with the IDN and B1 projects since the beginning of partner engagement. They have had a close relationship with Alice Peck Day due to being located on the same campus. This has allowed then to work collaboratively on shared patients. Headrest leadership is actively working with the DHMC system to become a more active part of their MDCT meetings. The largest challenges has been ensuring their processes is compliant with 42CFR.

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.

Performance Measure Name	Target	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	As of 12/31/19
# Organizations Assessing Medicaid Members with the CCSA	9	1	2	4	9	11(Updated to reflect B1 Core Partners)
# Organizations Contributing to and/or accessing Shared Care Plan	9	1	2	4	6	10
# Organizations Initiating Referrals to Supports	9	1	2	4	9	9
# Organizations Receiving Referrals to Supports	9	2	2	4	9	9
# of Organizations meeting requirements of "Coordinated Care Practice"	9	0	2	4	6	24 practices across 10 B1 Core Partners
# of Organizations meeting requirements of "Integrated Care Practice"	4	0	0	2	3	10 practices across 5 B1 Core Partners

Unmet areas in the table above are clarified below;

All designated partners have met the care coordination and/or integrated care designation as of December 31st, 2019. In fact, not included in this is Counseling Associates who has also met care coordination designation. Additionally, APD was not originally targeted as an integrated care practice, however they offer robust MAT services to their patients.

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 (Heater Rd, GIM)
- 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.

Other involved partners are:

- Phoenix House – Central Intake for has been approved in meeting CCSA requirement, is in coordination efforts to work with CMC and MFS to sit at the MDCT table.
- Counseling Associates – Has implemented a CCSA approved screening and has partnered with several primary care agencies in developing shared care plans through the MDCTs.
- Headrest – Is working diligently to be involved in several MDCTs

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.

As several project partners on boarded in the fall of 2018, many prepared to hire positions needed to fulfill the requirements of their integration efforts. Several of the organizations, APD, NHC, VRH, DHMC-GIM, Heater Road, Pediatrics, CMC and MCH, posted and hired for new positions. Only one planned for position has not been hired at this time which is a community health worker position at DHMC Pediatrics which is posted for hire.

As of reporting there have been no vacancies or turnover in IDN1 B1 hired positions. The IDN1 team has built in workforce recruitment incentive support in the form of sign on bonuses, loan repayment as eligible, and referral incentives which are being reported to greatly strengthen our organizational partner's ability to hire and retain clinical staff especially in the high need areas such as the BHC role.

Provider Type	IDN Workforce (FTEs)						
	Job Key:						
	CTC – Care Team Coordinator **CHW – Community Health Worker** **LMHC – Licensed Mental Health Counselor** **LCWS – Licensed Clinical Social Worker** **MLADC – Masters Licensed Alcohol Drug Counselor**				**APRN – Advanced Practice Registered Nurse** **RN – Registered Nurse** **BHC – Behavioral Health Clinician** **MSW – Masters Social Worker**		
	Projected Total Need	**Baseline Staffing on 6/30/17**	**Staffing on 12/31/17**	**Staffing on 6/30/18**	**Staffing on 12/31/18**	**Staffing on 6/30/19**	**Staffing on 12/31/19**
Dartmouth-Hitchcock Heater Rd Primary Care	1	1	1	1	1	2	**.17 Provider Champ** **.10 Psych Supervision** **2 CTC** **2 CHW** **.75 Project Manager** **.23 Resource Specialist**
Dartmouth-Hitchcock Psychiatry							
Dartmouth-Hitchcock General Internal Medicine							
Dartmouth-Hitchcock Pediatrics							
Dartmouth Hitchcock Keene/Cheshire Medical Center: Hospital Based Primary Care	1	0	0	Recruit to Hire for 1 Position	1	1 Shared with MFS. 3 Recruit to hire.	**1 APRN** **1 BHC (LCSW)** **1 CHW** **1 Project Manager**
Monadnock Family Services	1	0	0		1	1	**1 RN** **.05 Admin Support**
Alice Peck Day Hospital Based Primary Care Practice	1	0	0	0	1	1	**1 BHC (LMHC)**
Monadnock Hospital Primary Care-Peterborough Practice	1	0	0	0	1	1	**1 CHW** **1 MSW/MLADC**
New London Hospital and Medical Group Practice, Pediatric Care Practice, Newport Health Center	2	0	0	Recruit to Hire for 1 Position	1	1	**1 CHW** **.25 BHC (LCSW)** **.5 Project Manager**
Valley Regional Hospital Primary Care Practice	1	0	Recruit to Hire	1	1	3	**2 BHC (MSW)** **1 CHW** **.2 Project Manager**
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: IDN1 Integrated Healthcare Budget

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.

DHMC Lebanon System:

The IDN 1 administration previously support the DHMC Lebanon system on a per project basis. In July of 2019 with the contracting period, IDN 1 administration and DHMC Leadership agreed on a system level budget to better allocate positions for sustainability and to ensure a more efficient approach to tracking and use of funds. The first three budgets for the system are historical based on separate support, with the last budget highlighting the current budget effect July 1, 2019 through December 31, 2020. The budget is built of core awarded funds due to attribution.

B1: Heater Rd.	CY2016	CY2017	CY2018 Jan-June Actual	CY2018 Jul-Dec. Actual	CY2019 Jan-Jun Actual	CY2019 Jul-Dec Projected	CY2020 Contract Projected	CY2021 Projected
Salary								
Supervision								
Supplies								
Recurring Expenses								
Shared Care Plan								
MDCT								
Reporting/Clinical Quality								
IDN Participation								No Core Payment will be received after CY2020
MAT								
Other; Privacy/Consent Adherence								
Total								$ -
					Total Allocated	**$ 89,749.00**	**$ 179,498.00**	**$ -**

B1: General Internal Medicine	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Awarded	CY2019 Jan-Jul Actual	CY2019 Jul-Dec Projected	CY2020 Contract Projected	CY2021 Projected
Salary (MSW or BA Level Incl. Benefits)								
Supervision								
Supplies				$ 1,500.00		$ -	$ -	No Core Payment will be received after CY2020
Recurring Expenses				$ -		$ -	$ -	
Incentive Payments Based on Project Team Progress and Milestone Attainment- Awards will equal contracted total if 100% of milestones are met								
CCSA: SDoH/BH Screening								
Shared Care Plan								
MDCT								
Reporting/Clinical Quality								
IDN Participation								
MAT								
Other; Privacy/Consent Adherence								
Total								
					Total Allocated	**$ 89,749.00**	**$ 179,498.00**	**$ -**

B1: D-H Pediatrics	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
Salary (MSW or BA Level Incl. Benefits)							
Sign-on Bonus							
Loan Repayment							
CCSA: SDOH/BH Screening							
Shared Care Plan							
MDCT							
Reporting/Clinical Quality							
IDN Participation							
MAT							
Other; Privacy/Consent Adherence							
Total				$ 85,875.00	$ 181,050.75	$ 181,050.75	$ 75,375.00

DHMC System Budget July 1, 2019 – December 31, 2020

Segment	Role / Expense Item	FTE	#Hours per 1.0	Sal	Fringe	Total Expense
Heater Road	Provider Champion	0.01	3,120			
Heater Road	Psychiatry Supervision	0.05	3,120			
Heater Road	CTC	0.50	3,120			
Heater Road	CHW	1.00	3,120			
Heater Road	Project Manager	0.25	3,120			

Heater Road	Project Manager	0.25	3,120	[redacted]	[redacted]	[redacted]
GIM	Provider Champion	0.01	3,120	[redacted]	[redacted]	[redacted]
GIM	Psychiatry Supervision	0.05	3,120	[redacted]	[redacted]	[redacted]
GIM	CTC	0.50	3,120	[redacted]	[redacted]	[redacted]
GIM	CHW	1.00	3,120	[redacted]	[redacted]	[redacted]
GIM	Project Manager	0.25	3,120	[redacted]	[redacted]	[redacted]
GIM	Project Manager	0.25	3,120	[redacted]	[redacted]	[redacted]
Pedi	Pediatrician	0.05	3,120	[redacted]	[redacted]	[redacted]
Pedi	Pediatrician	0.05	3,120	[redacted]	[redacted]	[redacted]
Pedi	Pediatrician	0.05	3,120	[redacted]	[redacted]	[redacted]
Pedi	Care Team Coordinator	1.00	3,120	[redacted]	[redacted]	[redacted]
Pedi	Community Health Worker	1.00	2,080	[redacted]	[redacted]	[redacted]
	Supplies	-	-	[redacted]	[redacted]	[redacted]
	Training/Travel	-	-	[redacted]	[redacted]	[redacted]
	Capacity Building	-	-	[redacted]	[redacted]	[redacted]
Total		**-**	**-**	**$ -**	**$ -**	**$ 814,311.31**

B1: Valley Regional Hospital	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec Actual	CY 2019 Jan to June Actual	CY 2019 July to Dec Actual	CY 2020 Projected
Total Salary/Wages							
Employee Benefits							
Contract Position							
Supervision							
Supplies							
Travel							
Technology/Data/IT							
Contract Services							
Staff Education and Training							
Subcontracts/Agreements							
Total			$ 16,232.80	$ 66,763.30	$ 62,910.32	$ 77,989.24	$ 254,832.00

CCSA: SDoH/BH Screening						Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1
Shared Care Plan							
MDCT							
Reporting/Clinical Quality							
IDN Participation							
MAT							
Other; Privacy/Consent Adherence							
Total	$0.00	$0.00	$0.00	$0.00	0.00	$0.00	213,376.00

CMC/MFS & CMC System:

During the contracting period of July 1, 2019 through December 31, 2020 the addition of the IDN work with in CMC primary care greatly expanded. As a result the CMC budget now includes CMC primary care as well as the CMC/MFS bi-directional project budget. This approach allows for better tracking from a system perspective in allocating positions and resources.

B1: CMC	CY 2016 Actuals	CY 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to December Projected (Contract Award May, 18	CY 2019 Jan to June Actuals	CY 2019 July - Dec Actuals	CY 2020 Projected
Total Salary/Wages							
Employee Benefits							
Supplies							
Travel							
Staff Education and Training							
Office Space							
Other Expenses							
Total				$ 57,953.50	$ 62,250.51	$ 93,052.96	$ 616,946.36

Incentive Payments Based on Project Team Progress and Milestone Attainment- Awards will equal contracted total if 100% of milestones are met					
CCSA		N/A due to project start	Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1
Shared Care Plan					
MDCT					
Reporting/Clinical Quality					
IDN Participation					
MAT					
Other; Privacy/Consent Adherence					
Total		0	$0.00	75,625	151,250

MCH:

B1: Monadnock Community Hospital	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Awarded	CY2019 Jan-Jun Awarded	CY2019 Jul-Dec Projected	CY2020 Contract Projected
Salary							
Benefits							
Training and Staff Development							
Data and IT Support							
Travel							
Indirect				N/A due to project start			
Total						$ 39,937.59	$ 161,826.00
Incentive Payments Based on Project Team Progress and Milestone Attainment- Awards will equal contracted total if 100% of milestones are met							
CCSA							
Shared Care Plan							
MDCT							
Reporting/Clinical Quality							
IDN Participation						Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1
MAT							
Other; Privacy/Consent Adherence				N/A due to project start	N/A due to project start		
Total				$ -	$ -	$ -	$ -
Total Received / Allocated						**$ 39,937.59**	**$ 161,826.00**

B1: Alice Peck Day Hospital	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Awarded	CY2019 Jan-Jun Actuals	CY2019 Jul-Dec Projected	CY2020 Contract Projected	CY2021 Projected
Salary (MSW/BA Level Incl. Benefits)				Not Spent Due to Project Start				No core payment will be received after CY2020
Supervision								
Training and Staff Development								
Travel								
Total					$7,830.35	$35,847.00	$ 87,330.24	
Incentive Payments Based on Project Team Progress and Milestone Attainment- Awards will equal contracted total if 100% of milestones are met								
CCSA: SDoH/BH Screening				N/A due to project start	$1,650.00	Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1
Shared Care Plan								
MDCT								
Reporting/Clinical Quality								
IDN Participation								
MAT								
Other; Privacy/Consent Adherence								
Total				117,500	$9,480.35	$43,775.55	$87,551.11	

B1: New London Hospital/Newport Health Center	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Awarded	CY2019 Jan-June Actual	CY2019 July - Dec Actual	CY2020 Projected	CY2021 Projected
Salary								No core payment will be received after CY2020
Contracted PM (.05)								
Quality/Data (.04)								
Indirect								
				$ 35,884.45	$ 43,061.24	$ 91,055.90	$ 121,755.00	
CCSA: SDoH/BH Screening				$ -	Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1	Incentive Payments will be determined once Performance Payments are made to IDN1
Shared Care Plan								
MDCT								
Reporting/Clinical Quality								
IDN Participation								
MAT								
Other; Privacy/Consent Adherence								
Total				$35,884.45	$43,061.24	$64,581.00	$129,162.00	$ -

Community Support Partner Budgets:

B1: West Central Behavioral Health	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Actuals	CY2019 Jan-June Actuals	CY2019 July – Dec Actuals	CY2020 Projected
Community Engagement/Receptor of SDoH							
MDCT Participation							
Shared Care Plan							
Quality Reporting (no gaps)							
QI Project 1: Screening and Follow-Up							
QI Project 2: Primary Care -or- ED Utilization Focus							
Technology: Event Notification							
Technology: Shared Care Plan							
Technology: Quality Reporting Service							
Technology: Direct Secure Messaging							
Total Awarded				$ 21,500.00	$ 21,500.00	$ 35,450.67	$ 70,901.33

B1: Monadnock Family Services	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Actuals	CY2019 Jan-June Actuals	CY2019 July – Dec Actuals	CY2020 Projected
Community Engagement/Receptor of SDoH							
MDCT Participation							
Shared Care Plan							
Quality Reporting (no gaps)							
QI Project 1: Screening and Follow-Up							
QI Project 2: Primary Care -or- ED Utilization Focus							
Technology: Event Notification							
Technology: Shared Care Plan							
Technology: Quality Reporting Service							
Technology: Direct Secure Messaging							
Total Awarded				$ 21,500.00	$ 21,500.00	$ 38,049.67	$ 76,099.33

B1: Phoenix House	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Award	CY2019 Jul-Dec. Award	CY2020 Projected
Community Engagement/Receptor of SDoH						
MDCT Participation						
Shared Care Plan						
Reporting/Clinical Quality						

Total		$ 12,500.00	$ 25,000.00	$ 25,000.00

B1: Counseling Associates	CY2016	CY2017	CY2018 Jan-June	CY2018 Jul-Dec. Actuals	CY2019 Jan-June Actuals	CY2019 July - Dec Projected	CY2020 Projected
Community Engagement/Receptor of SDoH							
MDCT Participation							
Shared Care Plan							
Quality Reporting (no gaps)							
QI Project 1: Screening and Follow-Up							
QI Project 2: Primary Care -or- ED Utilization Focus							
Technology: Event Notification							
Technology: Shared Care Plan							
Technology: Quality Reporting Service							
Technology: Direct Secure Messaging							
Total Awarded					$ 11,500.00	$ 10,640.00	$ 18,088.00

B1 All Project Budgets

The final budget for each partner is refined through an iterative process as the IDN admin team balances attribution, available funds and helps each organization finalize its B1 scope of work and customize to the local environment. IDN 1 also offer 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. With the changing in contract to award team core funding for the remaining 18 months of the DSRIP work and additional incentive funds.

The budget table below includes total projections by organization site for the remaining year of project implementation expenditures through 2021 by CY. All of the B1 project contracts have been resigned for 7/1/19-12/31/2020. 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.

TABLE REDACTED

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, General Internal Medicine	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 Counseling Associates	Y 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
Abigail Kier	Practice Manager at GIM	Dartmouth Hitchcock General Internal Medicine Practice	Y
Dr. Will Torrey	Head of Psychiatry	Dartmouth Hitchcock Psychiatry	Y
Suellen Griffin	CEO	West Central Behavioral Health	Y
Dr. Andy Tremblay	Primary Care	Dartmouth Hitchcock Keene/Cheshire Medical Center Hospital Based Primary Care	Y
Phil Wyse	CEO	Monadnock Family Services	Y
Lauren Senn	Practice Manager	Alice Peck Day Hospital Based Primary Care Primary Care	Y
Barbara Mahar	VP of Operations	New London Hospital and Medical Group Practice	Y
		New London Pediatric Care	Y
		Newport Health Center Practice	Y
Judy Carr	Interim 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 was 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 were used, the IDN team require documentation of the alternate evidence based tools in the report on the data capture. The IDN1 Medical Director has approved the use of the substitute screening tool (s) for use as the CCSA.

CCSA Substitutes Approved as of 12/31/2019:

- DHMC Dartscreen – Pediatrics (used by Cheshire Medical Center and Alice Peck Day)
- Phoenix House – Central Intake Form
- West Central Behavioral Health – DLA20
- Monadnock Family Services- CANS ANSA

The table below reflects utilization by organization as of 6/30/19. At the other B1 project team sites (CMC, MFS, VRH) the IDN team is supporting the rollout of the CCSA process and building new clinical workflows around the process.

Providers	Utilization June 30, 2019 – December 31, 2019												
	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	Universal screening: GAD-7
	B1 Core Partners												
Alice Peck Day Primary Care													
• Family Medicine	CCSA in Use												
• Internal Medicine	CCSA in Use												
• Pediatrics	CCSA in Use												
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care													
• Family Medicine	CCSA in Use												
• Pediatrics	CCSA in Use												
Mary Hitchcock Memorial Hospital - Dartmouth Hitchcock Medical Center Primary Care Lebanon													
• North	CCSA in Use												
• South	CCSA in Use												
• General Internal Medicine	CCSA in Use												
• Pediatrics	CCSA in Use												
Mary Hitchcock Memorial Hospital	CCSA in Use												

Dartmouth Hitchcock Medical Center Psychiatry Lebanon		
Monadnock Family Services		CCSA in Use
Monadnock Community Hospital		
• Rindge Family Medicine		CCSA in Use
• Jaffrey Family Medicine		CCSA in Use
• New Ipswich Family Medicine		CCSA in Use
Newport Health Center Practice		
• Family Medicine		CCSA in Use
• Internal Medicine		CCSA in Use
• Pediatrics		CCSA in Use
New London Hospital		
• Primary Care		CCSA in Use (CCSA Capacity in place)
• Pediatrics		CCSA in Use
Valley Regional Hospital		
• Rindge Family Medicine		CCSA in Use
• Adult Internal Medicine*		CCSA in Use
• Valley Family Physicians*		CCSA in Use
West Central Behavioral Health		CCSA in Use

Counseling Associates		CCSA in Use
		B1 Support Partners (Not counted in CCD Requirements)
Headrest		Not in Use
Phoenix House		CCSA in Use
Waypoint (Child and Family Services)		Not in Use
Crotched Mountain Community Care		Not in Use
Teach Loving Connections (TLC) – Hope for Recovery		Not in Use
Mascoma Community Health Center		Not in Use

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

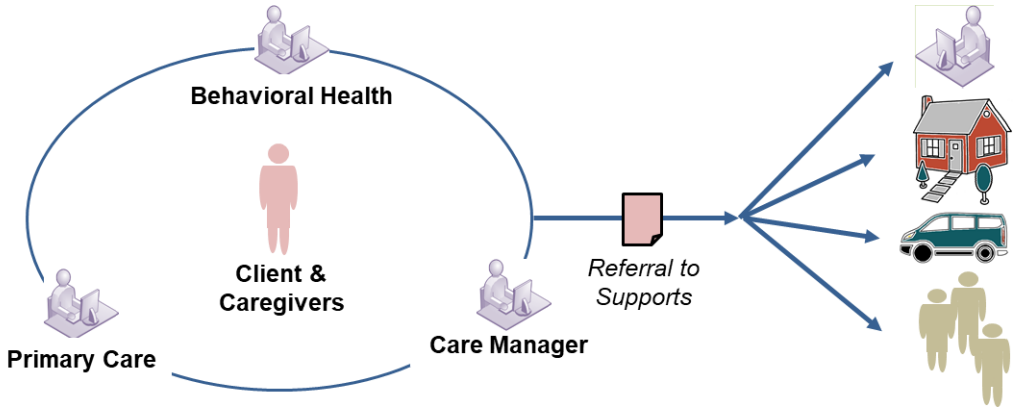
Introduction Error! Bookmark not defined.
Who Is to Be Screened, By Whom, Where, and When? Error! Bookmark not defined.
Screening Domains and Questions Error! Bookmark not defined.
Domain 1: Demographics: ..... Error! Bookmark not defined.
Domain 2: Depression ..... Error! Bookmark not defined.
Domain 3: Substance Use ..... Error! Bookmark not defined.
Domain 4: Medical ..... Error! Bookmark not defined.
Domain 5: Housing ..... Error! Bookmark not defined.
Domain 6: Family and Support Services (Social Isolation) ..... Error! Bookmark not defined.
Domain 7: Education ..... Error! Bookmark not defined.
Domain 8: Employment and Entitlements ..... Error! Bookmark not defined.
Domain 9: Legal ..... Error! Bookmark not defined.
Domain 10: Risk Assessment Including Suicide Risk ..... Error! Bookmark not defined.
Domain 11: Functional Status ..... Error! Bookmark not defined.
Domain 12: Developmental and Behavioral Health screening (Pediatrics) ... Error! Bookmark not defined.
Response to Positive Screens Error! Bookmark not defined.
Response Pathway 1: Immediate Response ..... Error! Bookmark not defined.
Response Pathway 2: Brief Intervention and Referral to Treatment ..... Error! Bookmark not defined.
Response Pathway 3: Brief Intervention and Referral to Supports ..... Error! Bookmark not defined.
Response Pathway 4: Enhanced Care Coordination ..... Error! Bookmark not defined.
Appendix A: Adult (age 18+) CCSA Questions, Survey Logic, and Interpretation Error! Bookmark not defined.

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	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. The DLA-20 is offered by MTM Services in Partnership with the National Council for Behavioral Health. They describe the instrument as follows: "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."
Adults Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) [New Hampshire	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. (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.)
Technical Assistance Protocol (TAP) 21	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.

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? *(Use "✔" to indicate your answer)*	**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

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.

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 1[5]
- 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

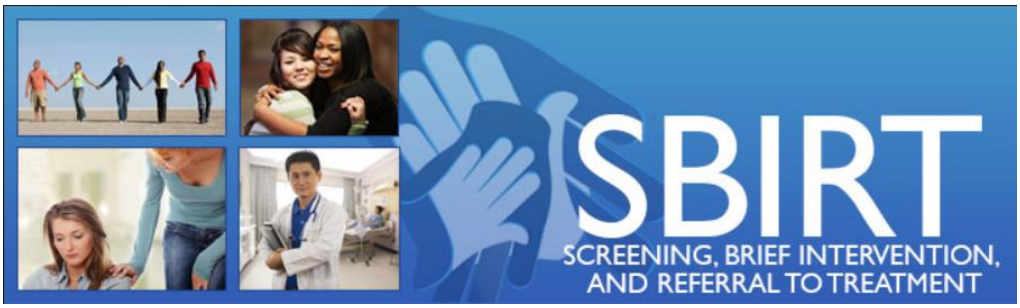
Region 1 recommends that Partners utilize current or develop new response protocol for positive screens for Interpersonal Safety and Suicide Risk.

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]



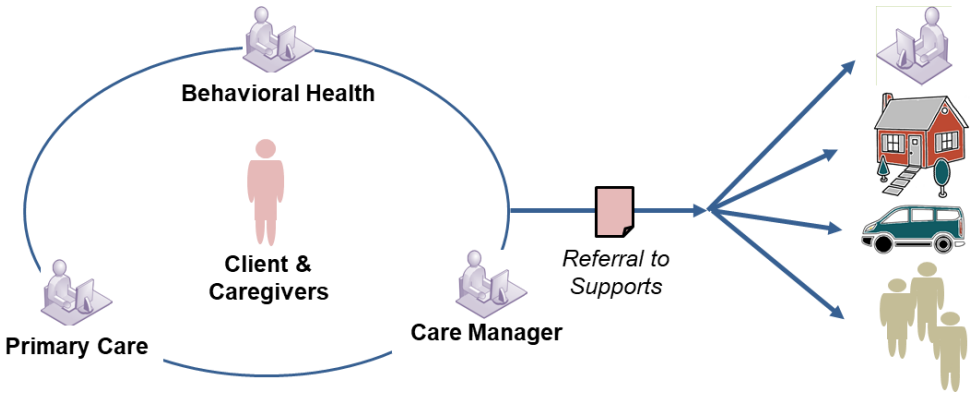
1. Partners should define how positive screens are identified, who in the office will conduct the brief intervention, and how this is documented.
2. Partners should define workflows for referrals to other providers. Referrals may be conducted through a variety of channels. Region 1 encourages Partners 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 of 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 has moved secondary to the Adult CCSA in most projects. IDN1 participated in discussions at D-H regarding the use of the Dartscreen as fulfillment of the required Pediatric CCSA domains which is being utilized by the DH Lebanon teams, Cheshire Medical Center and Alice Peck Day. Newport Health Center, Monadnock Community Hospital, and Valley Regional Hospital have developed Adolescent and Pediatric screeners outside of the Dartscreen, but have included the same behavioral health screens (PHQ-A, GAD-7, CRAFFT). The behavioral health partners used validated tools appropriate for their population.

Pediatric Providers CCSA Utilization			
		Utilization July 1, 2019 - December 31, 2019	
		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		Y	Y
Keene/Cheshire medical Center Primary Care		Y	Y
Dartmouth Hitchcock Heater Road Primary Care Practices		Y	Y
General Internal medicine		Y	Y
Dartmouth Hitchcock Psychiatry		Y	Y
Mondanock Family Services		Y	Y
Newport Health Center Practice		Y	Y
New London Hospital anad Medical Group Practice and Pediatric Primary Care Practice		Y	Y
Valley Regional Hospital Primary Care Practice		Y	Y
West Central Beahvioral Health		Y	Y
Counseling Associates		Y	Y

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. All IDN 1 practice sites are now holding MDCTs with SCPs uploaded into CMT.

	Multi-Disciplinary Care Team Members			
Providers	*Primary Care Staff Role*	*Behavioral Health Staff Role*	*Case Manager Staff Role*	*Community Members*
DHMC - Heater Road Primary Care	PCP	BHC, Psychiatry	CTC, RN Care Coordinator	West Central Behavioral Health, Pathways, Headreast
DHMC - General Internal Medicine Primary Care	PCP	BHC, Psychiatry	CTC, RN Care Coordinator	West Central Behavioral Health, Pathways, Headreast
DHMC - Pediatrics Primary Care	PCP	BHC, Psychiatry	CTC, RN Care Coordinator	West Central Behavioral Health, School System
DH - Cheshire Medical Center Primary Care	PCP	BHC, Psychiatry	CTC, RN Care Coordinator	Monadnock Family Services
Valley Regional Hospital Primary Care	PCP	BHC, Psychiatry	RN Care Coordinator	West Central Behavioral Health, Counseling Associates, School System, Groups
Alice Peck Day Primary Care	PCP, CHW	BHC, Psychiatry	BHC, CHW	West Central Behavioral Health, Headrest, Twin Pines
New London Hospital - Newport Health Center Primary Care	PCP, CHW	BHC, Psychiatry	BHC, CHW	West Central Behavioral Health, Counseling Associates
Monadnock Community Hospital Primary Care	PCP, CHW	BHC, Psychiatry	BHC, CHW	Internal Behavioral Health, Furture Monadnock Family Services

B1-8c. Required Training

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. The 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- 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
- Coordination with IDNs 4, 6 to bring a 1-day Cherokee Health System training to NH, with all IDN partner organizations represented. Additionally three webinars were provided.
- Motivational Interviewing – March 2019
- Circle of Security – January 2019. Was hosted by the PATP-IOP and the IDN funded additional opportunities for regional partners to attend.
- SBIRT Process – John Snow Institute, Center for Excellence
- IDN 1 also continues to fund spots at relevant statewide trainings available to partners including CHW training, NH Behavioral Health Summit and more.
- Each B1 Practice team has additional training dollars in their budget to address specific gaps in their organizations. These dollars have been used for specific behavioral health integration courses, chronic disease management, care coordination and more.

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.

In the next reporting period, the project manager and medical director will work to continue the robust training curriculum offered and strategizes on supporting partners in targeting specific operational challenges in integration as well as supporting community of practice groups to promote shared learning. IDN 1 administration requested an attestation from each core team member for required learnings, and ensuring they have resources easily available to them to support the gaps. The practices met gaps through review of previously recoded required trainings, or internally provided trainings by staff specialists.

See table below for training status as of 12/31/19:

For those trainings listed as offered the IDN1 team has made all necessary trainings available and requested attestation of all relevant staff completion but have not yet received confirmation of attainment.

Per write back request regarding number of staff trained per each site the IDN1 administrative team has passed along the request for attendee tracking at future trainings and in training attestation. The IDN1 partner teams can confirm that all B1 project team members have been included in the training table below.

	Diabetes Hyperglycemia		Dyslipidemia		Hypertension		Mental Health Topics (Multiple)		SUD Topics (Multiple)	
Providers	*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										
Heater Rd Practice Team 1	Attained		Attained		Attained		Attained		Attained	
General Internal Medicine	Attained		Attained		Attained		Attained		Attained	
Pediatrics	Attained		Attained		Attained		Attained		Attained	
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services	Attained		Attained		Attained		Attained		Attained	
Valley Regional Hospital	Attained		Attained		Attained		Attained		Attained	
Alice Peck Day Hospital Based Primary Care Practice	Attained		Attained		Attained		Attained		Attained	
New London Hospital and Medical Group Practice, Pediatric Care Practice, Newport Health Center Pediatric Practice	Attained		Attained		Attained		Attained		Attained	
Monadnock Community Hospital Primary Care	Attained		Attained		Attained		Attained		Attained	

B1-8d. Non Direct Care Staff Training

The Region 1 team has offered several web based trainings to all organization staff covering the domain areas listed below. Additionally, IDN 1 offers several slots to trainings hosted by other organizations and has hosted several trainings in the last semi-annual period. For all trainings that allow it these sessions are recorded and disseminated to all applicable organizations and staff through the Advisory Council list serve and posting on the IDN1 website. In addition, many teams have received training from aligned grants or through internal organizational knowledge and education.

For those trainings listed as offered the IDN1 team has made all necessary trainings available and requested attestation of all relevant staff completion but have not yet received confirmation of attainment.

Per write back request regarding number of staff trained per each site the IDN1 administrative team has passed along the request for attendee tracking at future trainings and in training attestation. The IDN1 partner teams can confirm that all B1 project team members have been included in the training table below.

Non Direct Care Staff Training Table

	Mental Health Topics (Multiple)		SUD Topics (Multiple)	
Providers	*PC Staff*	*BH Staff*	*PC Staff*	*BH Staff*
DHMC – Primary Care Sites and Psychiatry	Attained		Attained	
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care	Attained		Attained	
Valley Regional Hospital Primary Care	Attained		Attained	
Alice Peck Day Hospital Based Primary Care Practice	Attained		Attained	
New London Hospital/Newport Health Center	Attained		Attained	
Monadnock Community Hospital Primary Care	Attained		Attained	

B1-8e. Multi-Disciplinary Core Team Schedule

B1 partners have continued spreading MDCT meeting utilizing a SCP tool. All teams now meet at least monthly, with many choosing to meet more often to accommodate additional partners and comply with privacy regulations. As the teams look to onboard more community partners, several of them are now looking at restructuring to make the most use of everyone's time while still meeting privacy needs. In addition, many teams have met with partners outside of their regularly schedule meetings either for emergency purposes, or to accommodate unique cases.

	January 1, 2018 - June 30, 2018	July 1, 2018 - December 31, 2018	January 1, 2019 - June 30, 2019	July 1, 2019 - December 31, 2019
Providers				
DHMC - Heater Road	MDCT - 2nd Thursday/Month	MDCT - 2nd Thursday/Month	MDCT - 2nd Thursday/Month	MDCT - 2nd Thursday/Month
DHMC - GIM			MDCT - 2ND Monday/Month	MDCT - 2nd Monday/Month
DHMC - Pediatrics				MDCT - 3rd Friday/Month
Cheshire Medical Center				MDCT - 1st & 3rd Tuesday/Month
VRH - Valley Primary Care		MDCT - 3rd Tuesday/Month	MDCT - 3rd Tuesday/Month	MDCT - 2nd & 4th Tuesday/Month
VRH - Associates of Internal Medicine				MDCT - 2nd & 4th Tuesday/Month
Newport Health Center			MDCT - 4th Friday/Month	MDCT - 4th Friday/Month
Alice Peck Day			MDCT - 4th Tuesday/Month	MDCT - 3rd Thursday/Month
Monadnock Community Hospital - Jaffrey, Rindge, New Ipswitch				MDCT - 2nd Friday/Month

B1-8f. Secure Messaging

IDN-1 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 December 31, 2019, all IDN-1 Integrated Care Partners and 6 out of 7 Coordinated Care Partners are capable of using Direct Secure Messaging to exchange relevant health information for care coordination purposes and referrals. See Table 1 below. The only partner not yet using Direct Messaging is Phoenix House. IDN-1 has intentionally held back on deployment of Direct Secure Messaging with Phoenix House until they are actively working in a B1 project. As of 12/31/19, they were not engaged with any B1 projects. This will continue to be re-evaluated as additional partners are identified through work in that Region.

Table 1:

Detailed Status - Integrated Care Partners	
Organization	Capable of Direct Secure Messaging
Integrated Care Partners	
West Central Behavioral Health	
Dartmouth-Hitchcock Heater Road	
Dartmouth -Hitchcock GIM	
Dartmouth-Hitchcock Psychiatry	
Monadnock Community Hospital	
Coordinated Care Partners	
Valley Regional Hospital	
Monadnock Family Services	
Cheshire Medical Center / DH Clinic Keene	
Counseling Associates	
Alice Peck Day	
New London Hospital / Newport Health Center Practice	
Phoenix House	
Total	**11**
Target	**11**
% of Total	**100%**

In addition to the 12 organizations/practices involved in integrated care projects, 10 community organizations are also capable of exchanging Direct Messages. See Table 2 below.

Table 2:

B	D
Supporting IDN-1 Partners and Organizations	
Organization	**Capable of Direct Secure Messaging**
Child and Family Services	
Crotched Mountain Community Care	
Granite State Independent Living (GSIL)	
Headrest	
Home Healthcare, Hospice and Community Services	
Lake Sunapee Region VNA & Hospice	
Monadnock Collaborative (Claremont)	
Monadnock Collaborative (Keene)	
New Hampshire Hospital	
Pathways of the River Valley	
Planned Parenthood of Northern New England - Claremont	
Planned Parenthood of Northern New England - Keene	
Southwestern Community Services	
TLC Family Resource Center	
Visiting Nurse & Hospice of VT/NH	
Total	**10**
Target	**9**
% of Total	**111%**

As we stated in our previous reports, 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.

Secure Messaging: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

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.

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 such as CommonWell and Carequality 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 as it matures in the market and among our Partners' EHR vendors.
- Use of 'cross-entity view' access (e.g., DH Connect) is sufficient for many clinical coordination use cases and the IDN will support this mode of secure communication.

For partners using secure messaging tools either listed above or not listed please see protocol submission guidance on the back side of this page:

Secure Messaging: Protocol Submission

- If you are an IDN partner organization that is actively using Kno2 **there is no further information needed**
- If you are an IDN partner organization that is using another webmail application and are working directly with Mark Belanger and/or Jaime Dupuis **there is no further information needed**

- If your organization is using an alternate channel for secure communication with Partner organizations, and you have not engaged with the IDN previously around your process, please follow the steps below;
    - Submit a short 1 paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of use information to Jessica Powell at Jessica.J.Powell@hitchcock.org

B1-8g. Closed Loop Referrals (CLRP)

Guidance issued in the IDN1 B1 Protocols Document:

Closed Loop Referrals: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

IDN-1 Primary Care sites will interface with the Community Based Support Services organizations through a formal closed-loop referral process. The Care Team Coordinator or designated BH or CHW support staff 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)
- (pending pilot) UniteUs community support organization directory.

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 (or through UniteUs platform pending pilot in Sullivan County). 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 portal 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.

Closed Loop Referral: Protocol Submission

- If you are an IDN partner organization involved with a B1: Integrated Healthcare project that is actively using the process for closed loop referrals shared in the guidance protocol **there is no further information needed**
- If your organization is using an alternate process for ensuring closed loop referrals and you have not engaged with the IDN previously around your process please follow the steps below;
    - Submit a short 1 paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of information to Jessica Powell at Jessica.J.Powell@hitchcock.org

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

The following workflows and protocols have been supported by the Region 1 IDN team and were shared in the IDN1 B1 Protocols Document released in fall, 2018:

Interactions between Providers and Community Based Organizations: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

The Integrated Healthcare Core Team will use a formal closed-loop referral process (see Guidance Protocol on Pg. 4) to connect Medicaid Members with Community Based Organizations. The following protocol defines population to be served by level of acuity.

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 Acuity 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.

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

The population tier may be used by B1 project teams to help determine Multi-Disciplinary Team patients reviewed and the spread for use of the Shared Care Plan.

There is no submission format for this guidance protocol. IDN1 is working directly with partners.

Shared Care Plan: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

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 Team members
- Person-Centered Goals (e.g., Patient's identified goals)
- Health Concerns (e.g., Diagnoses, Problems, Social Determinants of Health needs)
- Shared Plan of Care informed by Primary Care and Behavioral Health
- Other relevant history from the Medicaid Member's Medical Records

IDN1 supports Shared Care Plan use through the use of the Collective Medical Technology platform

- For organizations not yet ready to use a web-based platform for shared care planning the IDN1 team will provide a paper version of the SCP fields
- Additionally, the IDN1 team will work with your organization and partners to progress readiness to the CMT tool.
- For partner organizations that follow the Cherokee Health pattern (e.g., The partner organization provides both primary care and behavioral health services, the organization integrates care internally, and there are no other organizations present in the sub-region that provide care to a significant number of Medicaid members) it is acceptable to share the care plan within a single EHR rather than a shared technology platform. IDN-1 encourages, but does not require, use of the CMT technology platform on top of the sharing that occurs in the Partner's EHR.

Pre-SCP Use:

1. All necessary privacy protections are in place including updates to patient privacy documentation and forms, scripts for explaining SCP to patients, and consent forms where required by law.
2. SCP Development Workflow – The IDN1 Program Director and QI Coach will support your team in developing a workflow and timeframe for SCP development.

SCP Use:

The minimum standard for IDN1 guidance states:

i. SCP development originates with PC EHR Chart Review, BHC EHR Chart Review (If external)
ii. PCP or BHC staff addresses patient goals at patient visit and review SCP content
iii. All participating providers see the SCP at least 24 hours before the MDCT meeting
iv. SCP is updated regularly with patient input

In addition, SCP should be made available to patients upon request or at discretion of Care Team.

Shared Care Plan: Protocol Submission

- If you are an IDN partner organization involved with a B1: Integrated Healthcare project that is actively using the CMT Shared Care Plan and your process has been reviewed with your project team there is no further information needed

- If your organization is enabled with CMT but the SCP is not yet in use and you are actively meeting with the IDN1 B1 or any Community-Based project team **there is no further information needed**
- If your organization is using an alternate process for SCP, not using the CMT technology, and you have previously reviewed this with the IDN1 team **there is no further information needed**
- If your organization is using an alternative process for shared care planning and you have not engaged with the IDN previously around your process please follow the steps below:
    - Submit a short 1 paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of use information to Jessica Powell at Jessica.J.Powell@hitchcock.org

Timely Communication: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

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

See the Closed Loop Referral: Guidance Protocol

• Referral Type - Based on urgency of care required, the referral can be marked as:

- Urgent Referral – immediate referral per phone
- Priority Referral – Referrals that require the patient to be seen within 3-14 days (from referral sent to patient seen)
- Routine Referral – Referrals that require the patient/client to be seen within 28 days (from referral sent to patient seen

Timely Communication: Protocol Submission

- If you are an IDN partner organization involved with a B1: Integrated Healthcare project that has achieved Coordinated Care Designation (CCD) **there is no further information needed**

- If your organization is actively meeting with a B1: Integrated Healthcare project but you have yet to complete the CCD milestones **there is no further information needed**
- If your organization is using an alternate communication framework for your related IDN1 project work and you have not engaged with the IDN previously around your process please follow the steps below:
    - Submit a short 1 paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of use information to Jessica Powell at Jessica.J.Powell@hitchcock.org

Privacy: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

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 and for Medicaid Members seeking care from Community Mental Health Centers. See section below for specific needs.

IDN1 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
- Shared Care Planning Consent form from Collective Medical Technology
- Privacy seminars, webinars, and individual meetings
- Access to legal advisory support from Hinkley Allen

For direct privacy support requests please contact the IDN1 Admin. Team

In accordance with the 1115 waiver special terms and conditions, and the SAMHSA finalized proposed changes to the Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2 the privacy recommended protocols should include the following:

- Ability to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2).
- Ability for additional disclosures of patient identifying information, with patient consent, to facilitate payment and healthcare operations such as claims management, quality assessment, and patient safety activities.
- Ability for additional disclosures of patient identifying information to certain contractors, subcontractors, and legal representatives for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation.
- Ability for permitting use of an abbreviated notice of prohibition on re-disclosure more easily accommodated in EHR text fields for users of electronic health records (EHRs).

There is no submission format for this guidance protocol. IDN1 is working with all network partners for adherence to privacy regulation and guidance.

Case Management Coordination: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

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.

For B1 Project Partners: 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.

See the guidelines below to manage shared patients:

Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.

i *Co-management with shared management for the disease* – the specialist shares long-term management with the primary care physician for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the primary care and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.

ii *Co-management with Principal Care for the Disease (Referral)* – the specialist assumes responsibility for the long-term, comprehensive management of a patient's referred medical/surgical condition. The primary care practice continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.

iii *Co-management with Principal Care for the Patient (Consuming illness)* – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or treatment has stabilized or completed. The primary care practice remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.

iv *Emergency Care* – medical or surgical can re obtain on an urgent or emergent basis.

See table below with care team agreement and role delineation;

Mutual Agreement

- Define responsibilities between PCP, Behavioral Health, and patient

- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, and follow-up
- Maintain competency and skills within scope of work & standard of care
- Give & accept respectful feedback when expectations, guidelines or standards of care are not met
- Agree on type of care that best fits the patient's needs

Expectations

Primary Care

- Follows principles of PCMH
- Manages Behavioral Health problem to the extent of the PCP's scope of practice, abilities & skills
- Follows standard practice guidelines related to evidence-based guidelines
- Resumes care of the patient as outlined by Behavioral Health & incorporates care plan recommendations into overall care of the patient
- Shares data with Behavioral Health in a timely manner including data from other providers

Behavioral Health

- Review information sent by PCP; address provider & patient concerns
- Confer with PCP & establish protocol before ordering additional services outside of practice guidelines
- Confers with PCP before referring to other specialists; uses preferred provider list
- Sends timely reports to PCP; shares data with care team
- Notifies PCP of major interventions, emergency care, & hospitalizations

There is no submission format for this guidance protocol. IDN1 is working with all network partners for on shared case management plans that work for the unique organization and their local environments.

Guidance above taken from:

© 2014 Closing the Referral Loop A Collaboration between The American Medical Association, The Pennsylvania Department of Health, and The Wright Center

Safe transitions (from institutional settings back to primary care, behavioral health and social support service providers): Guidance Protocol

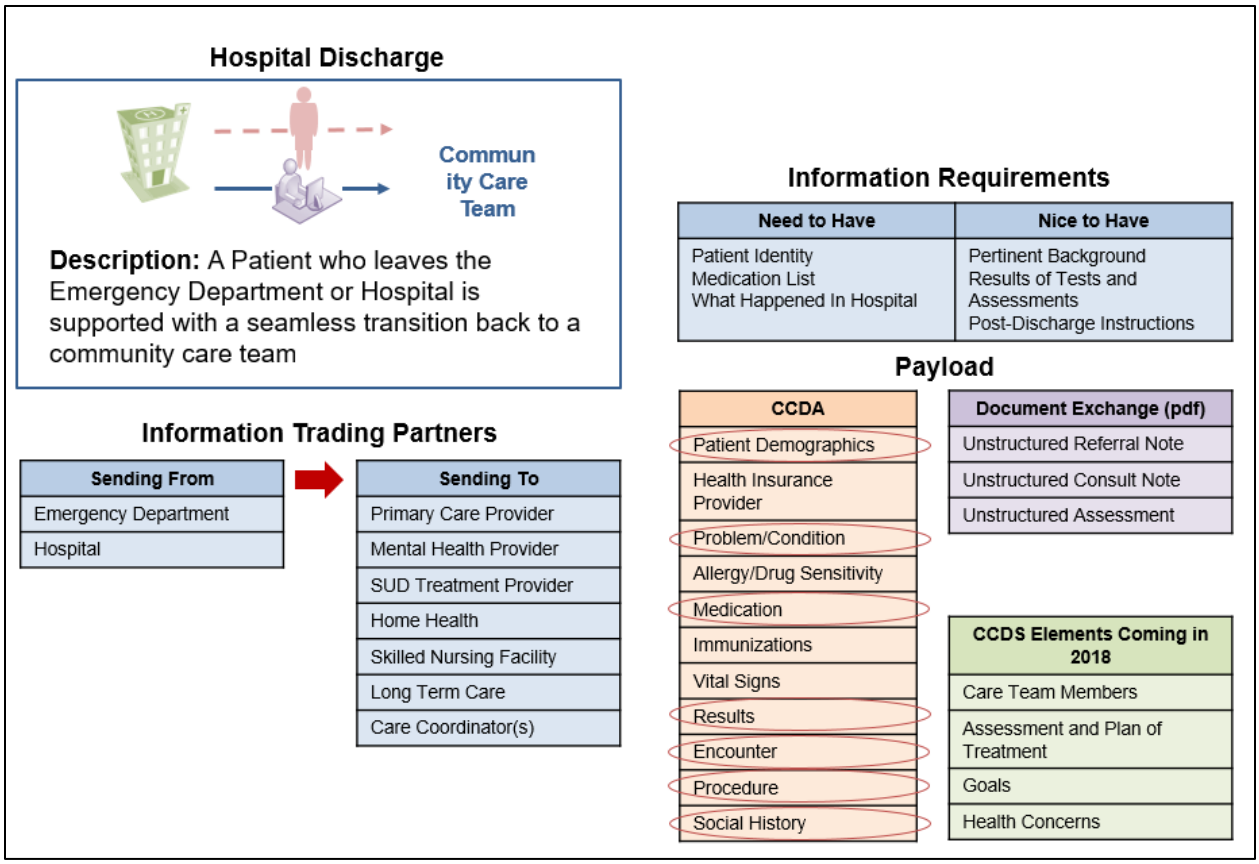
(Required for B1: Integrated Healthcare Project Partners)

IDN1 has implemented workflows with network partners to facilitate safe transitions from institutional settings back to primary care, behavioral health, and social support service providers. For a specific workflow request please contact the IDN1 Admin Team.

Priority Information to Support Transitions:

- 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.

See Graphic below for guidance on Hospital Discharge Workflow:



IDN1 recommends aligning all patient referrals and transitions management protocols with the six Institute of Medicine (IOM) aims of high-quality health care. :

• **Timely** - Patients receive needed transitions and consultative services without unnecessary delays.

• **Safe** - Referrals and transitions are planned and managed to prevent harm to patients from medical or administrative errors.

• **Effective** - Referrals and transitions are based on scientific knowledge, and executed well to maximize their benefit.

• **Patient-centered** - Referrals and transitions are responsive to patient and family needs and preferences.

• **Efficient** - Referrals and transitions are limited to those that are likely to benefit patients, and avoid unnecessary duplication of services.

• **Equitable** - The availability and quality of referrals and transitions does not vary by the personal characteristics of patients.

There is no submission format for this guidance protocol. IDN1 is working with all network partners for on care transition plans that work for the unique organization, population served and involved partner organizations.

Intake Procedures: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

Work Domain (Pre-Visit, Visit, Between Visit)	Activity/Task	Multi-disciplinary Team Member
Pre-Visit	Assist patient to prepare for visit: • bring medications to visit • prepare questions to ask provider • come in for pre-visit lab tests • invite family member/caregiver to visit if patient prefers • confirm need for interpreter	E.g., MA, receptionist
Visit-Before Pt/client arrives	Prepare intake packet in advance for each patient and place at the reception desk. • Pre-visit forms to identify patient goals for the visit • Medication lists • Patient-specific screens, E.g., CCSA	E.g., MA, receptionist
	Huddle	E.g., Provider, MA, Nurse, BHC, Receptionist
Visit	Give intake form(s) to the patient: meds, allergies, family history, past medical history Assess patient's educational needs	E.g., MA, receptionist
	Give med reconciliation list to patient and verify pharmacy	E.g., MA, nurse or provider
	Help patients identify their goals for the visit and for their health Share care plan with Pt/client	E.g., Nurse or provider
	Provide appropriate educational/self-management tools for patient Give after visit summary to patient and review with the patient	E.g., MA, nurse or provider
	Schedule patient for primary care follow-up, specialty appointments	E.g., receptionist
Between Visits	Follow-up on test results	E.g., nurse or provider

Monitor Health Maintenance and use Planned Care outreach process to help patients address gaps.	E.g., MA, receptionist, patient navigator/community health worker
Track all important appointments to completion	E.g., referral coordinator
Follow-up on missed appointments and/or referrals	E.g., referral coordinator
Schedule additional primary care and specialty appointments	
Routine care management/care coordination	E.g., care coordinator, nurse, social worker

Intake Procedures: Protocol Submission

- If you are an IDN partner organization involved with a B1: Integrated Healthcare project that has achieved Coordinated Care Designation (CCD) **there is no further information needed**
- If your organization is actively meeting with a B1: Integrated Healthcare project but you have yet to complete the CCD milestones there is no further information needed
- If your organization is using an alternate framework for intake activities for your related IDN1 project work and you have not engaged with the IDN previously around your process please follow the steps below:
    - Submit a short 1 paragraph narrative regarding your intake process, staff involved, timeline matrix, screenings used to Jessica Powell at Jessica.J.Powell@hitchcock.org

Adherence to NH Board of Medicine Guidelines on Opioid Use: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)

IDN1 Integrated Healthcare Partners are expected to be in adherence with the NH Board of Medicine's Opioid protocols. https://www.oplc.nh.gov/medicine/opioid-prescribing.htm

These rules include the following: (a) use of written treatment agreements; (b) provision of information to patients on topics such as risk of addiction and overdose, and safe storage and disposal; (c) use and documentation of opioid risk assessments; (d) prescription of the lowest effective dose; (e) use of informed consent forms; (f) periodic review of treatment plans; (g) required clinical coverage; and (h) use of random and periodic urine drug testing for patients using opioids long term.

IDN1 will continuously help inform prescribers of their responsibilities under NH law and Opioid rules. This includes connecting providers with resources offered by the State Government, the NH Medical Society, and multiple supporting organizations.

Specifically, IDN1 will promote use of the following resources with Partners that are updating their processes for opioid prescribing:

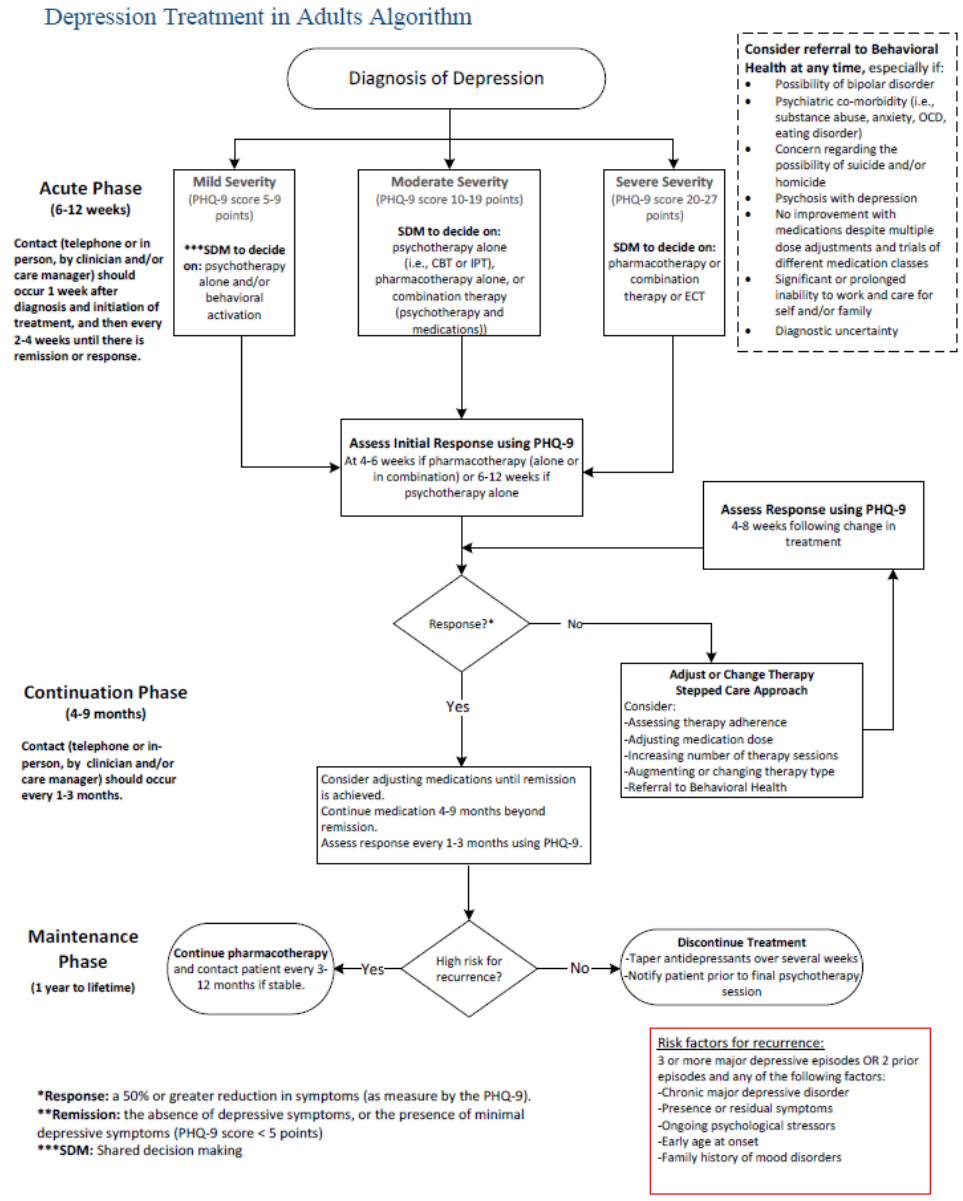
- NH Board of Medicine Resources: https://www.oplc.nh.gov/medicine/opioid-prescribing.htm
- Final Rule: PART Med 502 Opioid Prescribing:
  https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf
  https://www.nhms.org/sites/default/files/Pdfs/NH_BOM_opioid_rules_11-2-16.pdf
- Board-Approved Risk 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

Adherence to NH Board of Medicine Guidelines on Opioid Use: Protocol Submission

- If you are an IDN partner organization involved with a B1: Integrated Healthcare project that has achieved Coordinated Care Designation (CCD) **there is no further information needed**
- If your organization is actively meeting with a B1: Integrated Healthcare project but you have yet to complete the CCD milestones there is no further information needed
- If your organization is providing primary care services, MAT services, or involved in the treatment of SUD services and you have not engaged with the IDN previously around your adherence to the NH Board MG on Opioid Use please follow the steps below;
  - Submit a short 1 paragraph narrative regarding your organization adherence process to Jessica Powell at Jessica.J.Powell@hitchcock.org

Treatment of Mild to Moderate Depression: Guidance Protocol

(Required for B1: Integrated Healthcare Project Partners)



There is no submission format for this guidance protocol. If you would like additional guidance on treating Mild- Moderate Depression please request full treatment manual from IDN1 team.

Additionally, in the same document of bundled B1 protocols the IDN has developed the following to guide partner utilization of Event Notification:

Event Notifications: Guidance Protocol

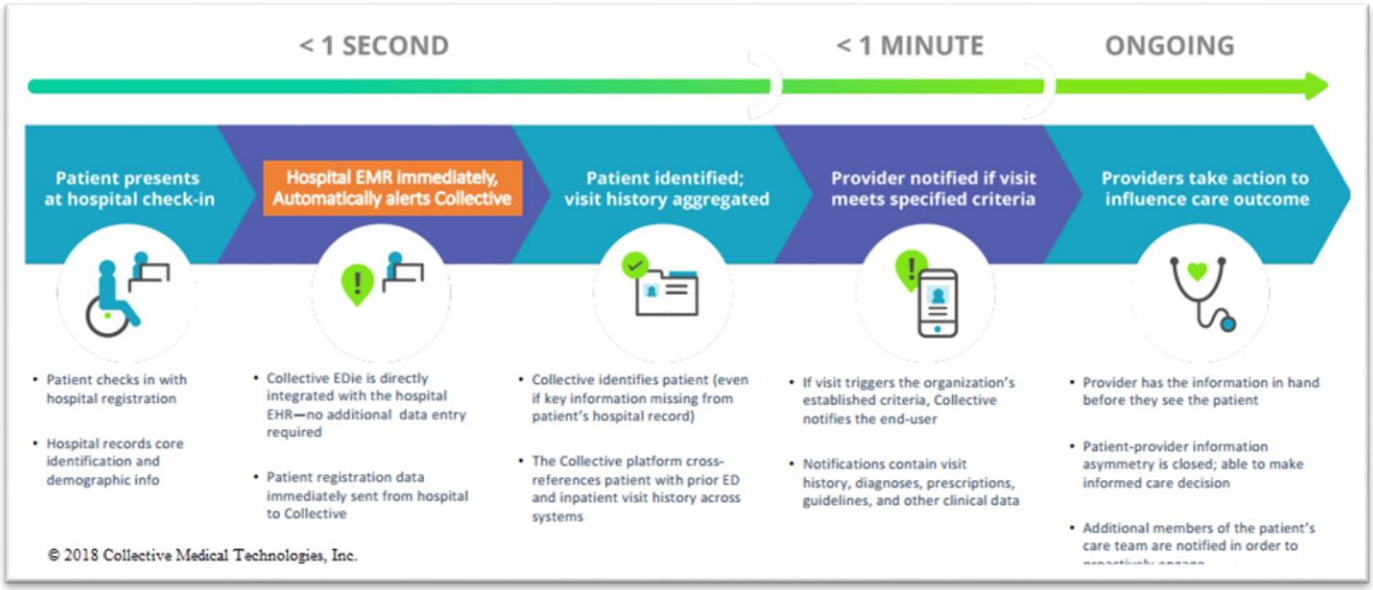
(Required for B1: Integrated Healthcare Project Partners)

The B1 Integrated Healthcare Project Partner organizations will utilize an Event Notification Service (ENS) to inform the team of admissions and discharges with an institutional setting.

IDN1 supports Event Notification Services through the use of the Collective Medical Technology (CMT) platform.

Pre-ENS Use:

- IDN1 will facilitate a session with CMT to discuss enrollment file specifications and file validation process, as well as any other setup and configuration required, including where notifications are to be sent.
- Once the set up process is complete and the file is validated and live in the CMT network, any time the patient is admitted/discharged from an ED/Inpatient setting (also in CMT network), the workflow below will kick off:



Privacy:

- Basic use of ENS to monitor a broad-base of Medicaid patients is acceptable and does not require the patient to provide consent.
- The relationship between the provider organization and the patient is not revealed unless that same patient is also involved in a B1 project for Shared Care Planning with CMT. In those instances:
    - All necessary privacy protections are in place including updates to patient privacy documentation and forms, scripts for explaining SCP to patients, and consent forms where required by law.

ENS Use:

- IDN1 will facilitate a training session with CMT to discuss best practices, workflows and additional reporting capabilities if needed to support projects as needed. Examples Include:

- Review Census reports regularly for any events you may not have been aware of;
- Monitor ED Utilizations reports for ED frequency or travelling around to different ED's;

Event Notifications: Protocol Submission

- If you are an IDN partner organization involved with a B1: Integrated Healthcare project that is actively using the CMT Event Notification Service and your process has been reviewed with your project team **there is no further information needed**

- If your organization is enabled with CMT but the ENS is not yet in use and you are actively meeting with the IDN1 B1 or any Community-Based project team **there is no further information needed**

- If your organization is using an alternate process for ENS, not using the CMT technology, and you have previously reviewed this with the IDN1 team **there is no further information needed**

- If your organization is using an alternative process for Event Notification Services and you have not engaged with the IDN previously around your process please follow the steps below:

    - Submit a short 1 paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of use information to Jessica Powell at Jessica.J.Powell@hitchcock.org

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	6/30/19	12/31/19
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: • 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) and • Universal screening using SBIRT	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	6/30/19	12/31/19
	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 developmental	Table listing all providers by domain indicating Y/N on progress for each process detail						
B1-8b	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	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: • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple)	Training schedule and Table listing all 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. OR you may provide a list of names of all individual providers to be trained in each						

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)					
			6/30/17	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19
		provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training						
12B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating 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	Documented work flows 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	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	6/30/19	12/31/19
	• Intake procedures that include systematically soliciting patient consent to confidentially share information among providers • 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, the IDN team has distributed four rounds of the site-self assessment, following the best practice guidance of every 6 months. The team will look to complete one more round in the spring of 2020*

2. Re-define B1 partner implementation waves as needed by 12/31/17: *Completed and Relaunched in March/April, 2018. All B1 contracts were reconfigured and distributed to capture the last 18 months of the Waiver with dates 7/1/19 – 12/31/2020. Included in the contracts are funding grids for core payments, distributed by meeting core requirements and incentive payments for supporting the improvement of performance metrics for the region.*

3. Engage partners in practice change initiatives starting in October, 2017: *Completed and recurring monthly. In the last year of the Waiver, teams will focus on entering into maintenance stage of change management and sustainability of structure implemented.*

    - Knowledge Exchanges in the final year will focus on solidifying good integration processes and shared learning/ networking.

4. Plan for secondary steps to achieve CCD status at each practice within 4-6 months of starting its B1 pilot: *Completed, each team has met CCD requirements as of 12/31/19. Teams will work to improve on implementation and sustainability.*
5. Continued implementation improvement across the IDN1 B1 partners
6. Ongoing Shared Care Planning and MDCT meetings with focus on improvement and expansion of partnerships

See B1-10 for additional information on CCD attainment across project teams

B1-9b. MAT

Updates as of December 31st, 2019:

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.

MAT and evidence based treatment of mild to moderate depression is currently in practice at the DH Lebanon clinics. MAT protocols are being refined at time of submission. DHMC has undergone a large initiative of expanding MAT services across the system which will deploy over the next year.

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

- Cheshire Medical Center – Refining through expansion grant
- Alice Peck Day
- Phoenix House
- DH-Psych (PATP)
- Monadnock Community Hospital

Through projects, the IDN team will assess and encourage expanded MAT and support for implementation. The Region 1 Medical Director has worked closely with the funded MAT initiative at the Multispecialty Clinic at Alice Peck Day Hospital and have been working to align this infrastructure with the rollout of a B1 project. Additionally, the Medical Director has been supporting the work Foundations for Health Communities is conducting to implement and improve MAT programs.

Region 1 IDN Administration continues to work closely with leaders of the Cheshire Medical Center and Dartmouth Hitchcock Hub & Spoke to ensure use and continuity throughout the region.

B1-9c. HIT: See tables below:

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
Integrated Care and Coordinated Care Partners				
West Central Behavioral Health	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: Yes	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: Yes
Dartmouth-Hitchcock Clinic Lebanon - Heater Road	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: Yes Other Referral Method: Yes
Dartmouth-Hitchcock Clinic Lebanon - GIM	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: Yes Other Referral Method: Yes
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: Yes Other Referral Method: Yes
Monadnock Community Hospital	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: Yes
Valley Regional Hospital, Valley Family Physicians	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: Yes
Monadnock Family Services	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: Yes
Cheshire Medical Center - Primary 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: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: Yes Other Referral Method: Yes
Counseling 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: Yes
Alice Peck Day 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: Yes
New London Hospital	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: Yes
Phoenix House	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: No CommonWell/Carequality: No Other Referral Method: Yes
Community Supports Partners				
Child and Family Services	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: No Other Referral Method: Yes
Crotched Mountain Community Care	Electronic Data System: Yes Pre-Manage: Yes	Electronic Data System: Yes Pre-Manage: Yes	Electronic Data System: Yes Pre-Manage: Yes	Direct Secure Messaging: Yes Other Referral Method: Yes
Granite State Independent Living	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes Other Referral Method: Yes
Headrest	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: No Other Referral Method: Yes
Home Healthcare, Hospice & Community Services	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes Other Referral Method: Yes
Lake Sunapee Region VNA & Hospice	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes Other Referral Method: Yes
Monadnock Collaborative - Claremont	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes Other Referral Method: Yes
Monadnock Collaborative - Keene	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes Other Referral Method: Yes
Pathways of the River Valley	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: No Other Referral Method: Yes
Planned Parenthood of Northern New England - Claremont	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: Yes
Planned Parenthood of Northern New England - Keene	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	CommonWell/Carequality: No Other Referral Method: Yes
Southwestern Community Services	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: No Other Referral Method: Yes
TLC Family Resource Center	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: Yes
Visiting Nurse and Hospice of NH/VT	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: Yes
Other Partners				
New Hampshire Hospital	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No	Direct Secure Messaging: No CommonWell/Carequality: No

Key:

- Little or no IT capability to support the
- 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 B1 teams are utilizing the CMT Ambulatory system to identify patients that are frequent users of area Emergency Departments. Teams are preparing to expand Medicaid lists to broaden hospital utilization. ED use is a strong indicator that patients are at risk and/or have complex care needs.
- IDN-1 is utilizing data submitted for DHHS Quality Reporting 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 now using CMT Ambulatory platform to document the Shared Care Plan developed through Multi-Disciplinary Care Teams. These electronic Shared Care Plans are available to anyone on the CMT network and allow others to support Patient and Care Team goals/actions.

  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 using 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)

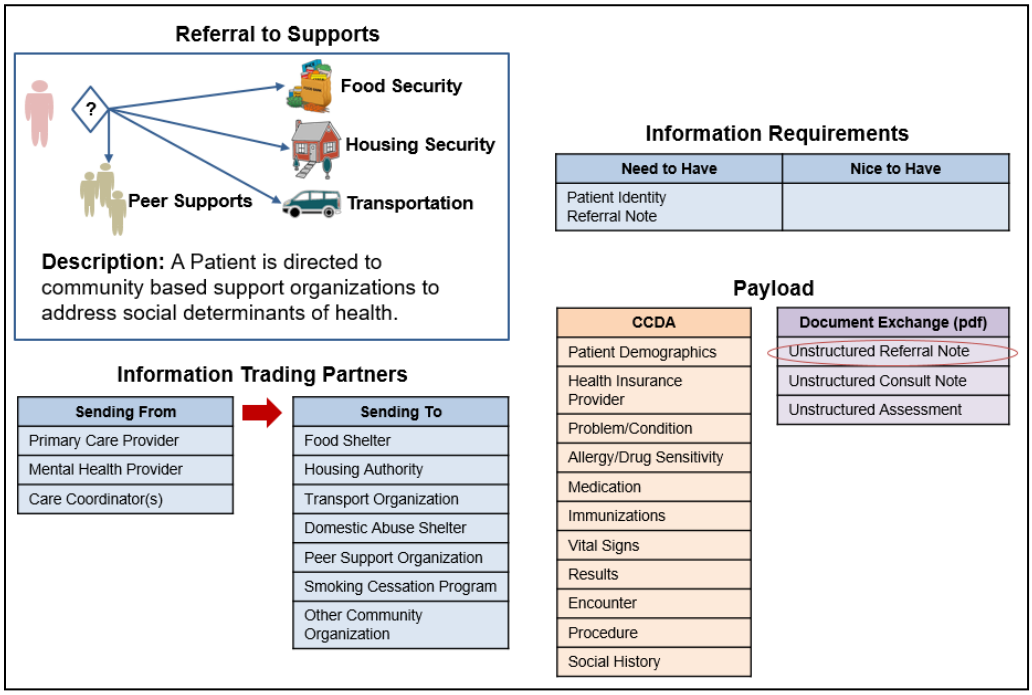
B1-9d. Joint Service Protocols and Communication Channels

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.

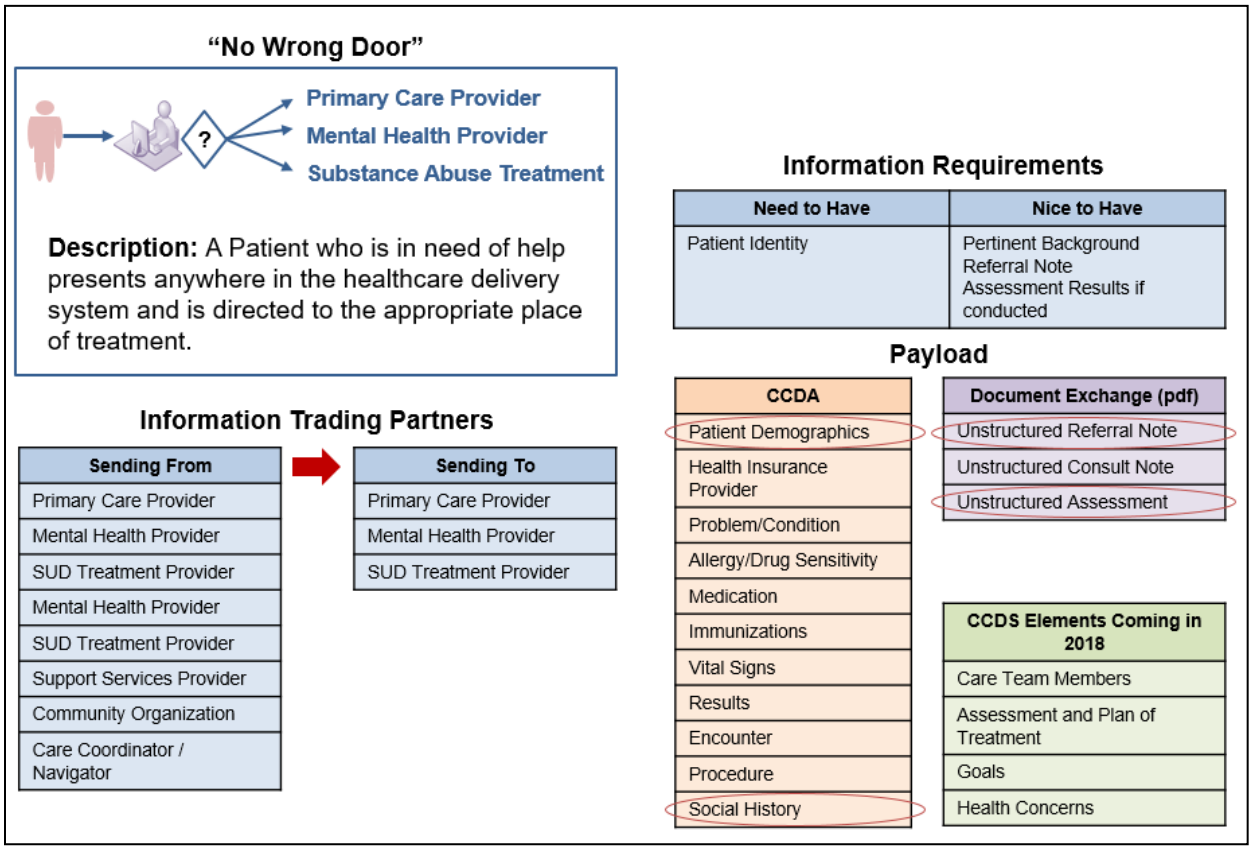
Figure 12: Referral to Supports Workflows



"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 13: "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	6/30/19	12/31/19
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: • 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	•	• Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	• Table listing all providers indicating progress on each process detail						
B1-9d		Documented work flows with community based social support service providers including, at minimum: • 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	Number Designated 6/30/19	Number Designated 12/31/19
Coordinated Care Practice	10	0	1	2	3	5	24 Coordinated Care Designation Practices across 10 B1 Core Partners (see table below)
Integrated Care Practice	4	0	0	2	3	3	10 Integrated Care Practices across 5 B1 Core Practices

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

	List of providers identified to make progress toward Coordinated Care Practice designation (CCD)	12/31/17	6/30/18	12/31/18	6/30/19	12/31/19

	1 CCD	6 CCD	9 CCD	9 CCD	24 Coordinated Care Designation Practices across 10 B1 Core Partners
B1 Core Partners (practices of each B1 core partner are listed under the larger organization – CCD requirement met are indicated with a *)					
Alice Peck Day Memorial Hospital • Family Medicine* • Internal Medicine* • Pediatrics*	• Participation at IDN1 All partner events	• Ongoing meetings with IDN1 leadership to determine B1 project launch and RFP	• Monthly project team meetings with clinical, administrative and IDN team membership • Recruit to hire for clinical positions • CCSA vetting underway • MDCT workflows underway • SCP in process • IDN reporting	• Monthly project team meetings with clinical, administrative and IDN team membership • Hired BHC position • CCSA live • MDCT workflows developed in partnership with WCBH • SCP utilized via paper, onboarding CM platform • IDN reporting	• Once monthly project team meetings • Hired BHC position • CCSA Implemented • MDCT with SCP on CM Implemented • Workflows developed and implemented • IDN Reporting • Training Complete • All three practices meeting CCD
Cheshire Medical Center/Dartmouth Hitchcock Keene (2) • Family Medicine* • Pediatrics*	• Submitted Project Proposal with MFS in July, 2017 B1 RFP • On hold until transitions within PC are Complete	• 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	• Monthly project team meetings with clinical, administrative and IDN team membership • APRN Hired • Clinical space completed at MFS • Training underway for APRN, RN, and Admin. supports • QI activities and facilitation provided by CHI • Pending launch of MDCT, SCP	• Monthly project team meetings with clinical, administrative and IDN team membership • APRN Hired • Clinical space completed at MFS • Training complete for APRN, RN, and Admin. supports • QI activities and facilitation provided by CHI • Pending launch of MDCT, SCP with onboard of CMC primary care	• Bi-weekly project team meetings • APRN, BHC, CHW Hired • CCSA Implemented • MDCT and SCP on CM platform implemented • Workflows developed and implemented • IDN Reporting • Bi-directional clinic in MFS operating since April 2019 • All Practices Meeting CCD designation

			• QI activities and facilitation provided by CHI	• Pending launch of CCSA across all PC • IDN reporting	• Pending launch of CCSA across all PC • IDN reporting	• Looking to expand to satellite clinics through technology improvement
	Counseling Associates*	• Came onboard with IDN1 as a B1 partner • Signed Subcontract with VRH for B1 project support	• Project team meetings with VRH B1 team • Conversations for B1 support with NLH/NHC project team	• CCSA in use • Participation in project team, MDCT at VRH • Ongoing collaboration with NHC and pending MDCT participation • IDN reporting	• CCSA in use • Participation in project team, MDCT at VRH and NHC • Ongoing collaboration with APD and DHMC pending • IDN reporting	• CCSA Implemented • MDCT participation at VRH, NHC planning for DHMC and APD • Use of CM • IDN Reporting • Workflows developed and implemented • CCD Designation met

	Mary Hitchcock Memorial Hospital - Dartmouth Hitchcock Medical Center Primary Care Lebanon
	• Heater Road Primary Care
	  ○ North*
	  ○ South*
	• General Internal Medicine*
	• Pediatrics*
		• Onboard with Project Planning
		• Participation at all IDN1 all partner events
		• Recruit to hire for CTC position
			• Ongoing bi-weekly meetings and implementation of SDoH Screener
			• Participation in MDCT, SCP
				• Ongoing bi-weekly meetings and implementation of CCSA
				• Participation in MDCT, SCP on CMT platform with WCBH
				• IDN reporting
				• Training Completed
				• Workflows developed and implemented
					• Ongoing bi-weekly meetings and implementation of CCSA
					• Participation in MDCT, SCP on CMT Platform with WCBH
					• IDN reporting
					• Training Completed
					• Workflows developed and implemented
						• Monthly project team meetings
						• CCSA Implemented
						• Monthly MDCT meetings with SCP on CMT in partnership with WCBH, ED staff, Headrest, Pathways
						• Training Completed
						• Workflows developed and implemented

	Mary Hitchcock Memorial Hospital Dartmouth Hitchcock Medical Center Psychiatry Lebanon*	• Onboard with Project Planning • Participation at all IDN1 all partner events	• Ongoing bi-weekly meetings and implementation of CCSA • Participation in MDCT, SCP	• Ongoing bi-weekly meetings • Participation in MDCT, SCP • IDN reporting	• Ongoing bi-weekly meetings • Participation in MDCT, SCP • IDN reporting	• Once monthly project team meetings • Ongoing participation with all primary care teams for MDCT and SCP • IDN Reporting • CCSA provided to patient through primary care

						• Workflows developed and implemented • CCD met
	Monadnock Community Hospital • Rindge Family Medicine* • Jaffrey Family Medicine* • New Ipswich Family Medicine*	• Participation at IDN1 All partner events	• Ongoing work with IDN1 Admin. team to develop RFP details, Project framework and draft SOW for Subcontract	• Monthly project team meetings with clinical, administrative and IDN team membership • Recruit to hire for clinical positions • CCSA vetting underway • MDCT workflows underway • SCP in process • IDN reporting	• Monthly project team meetings with clinical, administrative and IDN team membership • Recruit to hire for clinical positions • CCSA vetting underway • MDCT workflows underway • SCP in process • IDN reporting	• Bi-weekly project team meetings • Once monthly MDCT meetings with SCP on CM with internal BH department, expanding to MFS and community services • Hired MLADC/LCMHT, CHW • IDN Reporting • Workflows developed and implemented • CCD Met at all three practices
	Monadnock Family Services*	• Partner proposal with CMC for B1 RFP in July, 2017	• Participation in monthly B1 project team meetings	• CCSA in use • Enabled use of SCP • Participation in monthly B1 project team meetings • Clinical space established • Information sessions held with clients regarding new PC services on site • IDN reporting	• CCSA in use • Enabled use of SCP • Participation in monthly B1 project team meetings • Clinical space established • New APRN seeing patient on site • IDN reporting	• CCSA Implemented • MDCT participation with CMC Primary Care including CMT SCP access • CMC APRN active in clinic since April, 2019 • IDN Reporting • Practice meeting CCD

	New London Hospital/Newport Health Center NLH • Primary Care* • Pediatrics* NHC • Family Medicine* • Internal Medicine* • Pediatrics*	• 2 Meetings held with IDN Admin. team to discuss next steps for B1 Involvement	• Ongoing work with IDN1 Admin. team to develop RFP details, Project framework and draft SOW for Subcontract	• Contract signed for all practice teams • Bi-weekly meetings underway with NHC project team • CCSA developed • SCP enabled and training underway • MDCT schedule established and workflow in place • IDN reporting	• Contract signed for all practice teams • Bi-weekly meetings underway with NHC project team • CCSA fully implemented across all of NHC primary care • SCP utilized via paper for all NHC patient presentations • MDCT meeting active • IDN reporting	• CCSA Implemented • MDCT with SCP on CMT platform implemented with CA and WCBH • Once monthly project team meetings. • Workflows developed and implemented • IDN Reporting • Four practices meeting CCD
	Valley Regional Hospital (3) • Valley Regional Primary Care* • Adult Internal Medicine* • Valley Family Physicians*	• Submission of B1 RFP and Project Launch	• Ongoing bi-weekly meetings and pre-implementation infrastructure development for Fall patient deployment	• Ongoing bi-weekly meetings • Monthly MDCT underway • Use of SCP • Use of all B1 protocols • Use of CCSA in place • Continued spread to all VPC providers	• Ongoing bi-weekly meetings • Monthly MDCT with community partners • Use of SCP through CMT • Use of all B1 protocols • Use of CCSA in place • Spread to all providers both pediatric and adult.	• Once monthly project team meetings • Monthly MDCT meetings with SCP on CMT • CCSA implemented • Workflows developed and implemented • IDN Reporting • Training Completed • Three practices meeting CCD
	West Central Behavioral Health*	• Onboard with Project Planning • Participation at all IDN1 all partner events	• Implementation of CCSA • Participation in MDCT, SCP with DHMC	• Implementation of CCSA • Participation in MDCT, SCP with DHMC • IDN reporting	• Implementation of CCSA • Participation in MDCT, SCP with DHMC, VRH • IDN reporting	• Implementation of CCSA • Participation in MDCT, SCP with DHMC, VRH, NHC, APD • IDN reporting • CCD Met
	B1 Support Partners (Not counted towards total CCD)					

	Headrest	• Participation at IDN1 All partner events	• Participation at IDN1 All partner events • Support of DH-HRS SUD initiatives and participation with B1 MDCT underway	• Engagement in MDCT, SCP usage with HRS team • Participation in all IDN1 partner events	• Engagement in MDCT, SCP usage with HRS team • Participation in all IDN1 partner events	• Engagement in MDCT, SCP usage with DHMC and APD teams • Participation in all IDN1 partner events
	Phoenix House	• Participation at IDN1 All partner events	• Participation at IDN1 All partner events • Support of CMC SUD initiatives and coordination for B1	• Participation at IDN1 All partner events • Use of internal TAP21 for CCSA • IDN reporting • Support in • of CMC SUD initiatives and coordination for B1	• Participation at IDN1 All partner events • Use of internal TAP21 for CCSA • IDN reporting • Support in CMC SUD initiatives and coordination for B1	• Participation at IDN1 All partner events • Use of internal TAP21 for CCSA • IDN reporting • Support in CMC SUD initiatives and coordination for B1
	Waypoint (Child and Family Services)	• Participation at IDN1 All partner events	• Participation at IDN1 All partner events	• Participation at IDN1 All partner events • Name change to Waypoint • Support of Upper Valley B1 projects pending	• Participation at IDN1 All partner events • Name change to Waypoint • Support of Upper Valley B1 projects pending • Pending participation of MDCT with APD	• Participation at IDN1 All partner events • Name change to Waypoint • Support of Upper Valley B1 projects pending MDCT Expansion
	Crotched Mountain Community Care	• Participate in all IDN 1 Partner Events	• As an aging resource and low Medicaid population, partner has been unengaged in B1 project work	• As an aging resource and low Medicaid population, partner has been unengaged in B1 project work	• As an aging resource and low Medicaid population, partner has been unengaged in B1 project work	• As an aging resource and low Medicaid population, partner has been unengaged in B1 project work

	Teach Loving Connections (TLC) – Hope for Recovery	• Participate in all IDN 1 Partner Events	• Participate in all IDN 1 Partner Events	• Hope for Recovery provided peer support groups and 1 on 1 coaching for SUD recovery	• Support pediatric clinics at VRH, NHC, APD in meeting family needs identified by CCSA • Hope for Recovery provided peer support groups and 1 on 1 coaching for SUD recovery	• Has been in discussion with teams for MDCT • Support pediatric clinics at VRH, NHC, APD in meeting family needs identified by CCSA • Hope for Recovery provided peer support groups and 1 on 1 coaching for SUD recovery
	Mascoma Community Health Center (Not Counted as B1)	Participation at IDN1 All partner events	Participation at IDN1 All partner events	Given less than 100 Medicaid members being served IDN1 in agreement with DHHS will not pursue further for CCD attainment	Given less than 100 Medicaid members being served IDN1 in agreement with DHHS will not pursue further for CCD attainment	Given less than 100 Medicaid members being served IDN1 in agreement with DHHS will not pursue further for CCD attainment

Progress Toward Integrated Care Practice						
List of providers identified to make progress toward Integrated Care Practice designation		12/31/17	6/30/18	12/31/18	6/30/2019	12/31/19
		0	2	3	3	10 integrated care practices across 5 B1 core partners
B1 Core Partners Meeting Integrated Care Designation (Organizations listed with individual practices under them. Each integrated care practice has also met Coordinated Care Designation (CCD) as outlined in the CCD B1-10 table. Met practices indicated with a *)						
	West Central Behavioral Health *	• Onboard with Project Planning	• Ongoing bi-weekly meetings and	• Ongoing bi-weekly meetings and	• Ongoing bi-weekly meetings and	• MAT Services implemented

		• Participation at all IDN1 all partner events	implementation of CCSA • Participation in MDCT, SCP	implementation of CCSA • Participation in MDCT, SCP • IDN reporting	implementation of CCSA • Participation in MDCT, SCP • IDN reporting	• Treatment for moderate to severe depression implemented

	Mary Hitchcock Memorial Hospital - Dartmouth Hitchcock Medical Center Primary Care Lebanon
	• Heater Road Primary Care
	  ○ North*
	  ○ South*
	• General Internal Medicine*
	• Pediatrics
		• Onboard with Project Planning
		• Participation at all IDN1 all partner events
		• Recruit to hire for CTC position
			• Ongoing bi-weekly meetings and implementation of SDoH Screener
			• Participation in MDCT, SCP
				• Ongoing bi-weekly meetings and implementation of CCSA
				• Participation in MDCT, SCP
				• IDN reporting
					• Ongoing bi-weekly meetings and implementation of CCSA
					• Participation in MDCT, SCP
					• IDN reporting
						• MAT Services implemented through several departmental programs including systems addiction treatment program with specialty care in pregnant women and mothers
						• Treatment for moderate to severe depression implemented

	Monadnock Community Hospital • Rindge Family Medicine* • Jaffrey Family Medicine* • New Ipswitch Family Medicine*	• Participation at IDN1 All partner events	• Ongoing work with IDN1 Admin. team to develop RFP details, Project framework and draft SOW for Subcontract	• Monthly project team meetings with clinical, administrative and IDN team membership • Recruit to hire for clinical positions • CCSA vetting underway • MDCT workflows underway • SCP in process • IDN reporting	• Monthly project team meetings with clinical, administrative and IDN team membership • Recruit to hire for clinical positions • CCSA vetting underway • MDCT workflows underway • SCP in process • IDN reporting	• MAT Services implemented through behavioral health department support and workflows • Treatment for moderate to severe depression implemented

	Mary Hitchcock Memorial Hospital Dartmouth Hitchcock Medical Center Psychiatry Lebanon*	• Onboard with Project Planning • Participation at all IDN1 all partner events	• Ongoing bi-weekly meetings and implementation of CCSA • Participation in MDCT, SCP	• Ongoing bi-weekly meetings • Participation in MDCT, SCP • IDN reporting	• Ongoing bi-weekly meetings • Participation in MDCT, SCP • IDN reporting	• MAT services implemented as departments Addiction Treatment Program and Moms in Recovery Program • Treatment for moderate to severe depression implemented
	Alice Peck Day Memorial Hospital • Family Medicine* • Internal Medicine* • Pediatrics	• Onboard with Project Planning	• Onboard with Project Planning	• Working on CCD Requirements • Robust partnership with Headrest • Waivered PCPs	• Working on CCD Requirements • Robust partnership with Headrest • Waivered PCPs	• Achieved CCD Requirements • Robust partnership with Headrest with shared RN Care Coordinator and weekly team meetings. Organizations on same campus • Waivered PCPs

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

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

Updates for Co-Pilot July- December, 2019:

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. The team underwent one staff transition during the semi-annual term with one of the positions internally promoted. The team was able to fill the position and continue to maintain full caseloads for both referral streams within the project. The team transitioned to once monthly two hour meetings which has a blended focus of clinical content and operations. The E5 and C1 teams review referrals as a cohort and determine the best team member to work with each client based on a number of factors assessing best fit. Additionally the case managers review cases with the larger teams for the purpose of case progress updates, or to secure team support with particular clients on an as needed basis. The teams address operational needs during this meeting, such as improvement in referral flows, communication or data tracking. The merged meeting also presents an opportunity for further trainings. Due to staffing turnover in late CY2018 and early CY2019 members of both teams are relatively new, and despite having attended standard onboarding trainings, the team has built a culture which promotes continued learning and reinforces these opportunities. The leadership of both organizations are a part of the team and will provide in the moment training such as how to work with someone who has suicidal ideation as content areas and need arise

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.

The teams have reported better workflow and communication with a clearer separation of the two project referral streams. Monadnock Collaborative works with the Critical Time Intervention (CTI) clients and Monadnock Family Services works with the enhanced care coordination clients. With the change early in the reporting period, the CTI team developed new workflow, client forms which they have collated into a central program binder. Below are the workflow and forms included in their binder;

Copilot CTI and ECC

In-House Operational Workflow

9-29-18 last updated on 8/26/19

WHAT:
Copilot CTI and ECC Referrals

HOW:
Referrals flow through ServiceLink/Copilot Referral Coordinator

CMC-DHK hospital staff make referrals to ServiceLink/Copilot via E-Discharge. Clinic and partner staff make referrals to Copilot using approved Copilot referral form and fax the referral to Monadnock Collaborative/Monadnock ServiceLink by fax at 603-352-8822.

Copilot referrals are made according to one three types of referral source per chart below:

	Hospital or Emergency Room	**Primary Care Provider**	**Designated/Partnering Community-Based Social Service Agency**
Referral Criteria:	Complex Physical Health Challenge + Apparent Mental Health and/or Substance Misuse Challenge + Active or likely eligible for Medicaid	Complex Physical Health Challenge + Apparent Mental Health and/or Substance Misuse Challenge + Active or likely eligible for Medicaid	Complex Physical Health Challenge + Apparent Mental Health and/or Substance Misuse Challenge + Active or likely eligible for Medicaid
Referral Tool:	CTI Referral Form	ECC Referral Form	ECC Referral Form
Referral Pathway current:	E-Discharge Verbal (phone/in person)	Fax Mail	Fax Mail
OPTIONS for FUTURE	EPIC FAX	KNO2 EPIC	KNO2

REFERRAL RECEIPT, REVIEW AND DOCUMENTATION OF ALL COPILOT REFERRALS

1. **Copilot Referral Coordinator:**

- Reviews E-Discharge and Fax Referrals Daily on regular business day

- Enters referral information into Refer 7 database and records the referral according to program type so that data can be pulled from Refer 7 and cross checked with spreadsheets
- Enters referral information onto Copilot CTI or ECC tracking sheet
- The referral coordinator then researches the history of the person referred according to the following steps:
    1) Looks at any notes and/or information provided via E-discharge and/or in the CMC-DHK EMR.
    2) Looks up name in Refer 7 to see if there is already documentation on person that would help inform next steps
    3) Looks up name in New Heights to determine if there is a NH DHHS Medicaid/APTD/MEAD or other status recorded in any way, either current, pending, or denied.
        a. Looks in New Heights to determine if a waivered Case Management service is in place and a CFI case manager or Case Management Company is assigned. Documents this information as part of referral.
        b. Checks with MFS staff to see if person is a current MFS client and if the person has MFS case management or other MFS service staff assigned. Documents as part of referral.

NOTE 1:
Cross checking systems is critical to supporting the person in the most streamlined manner and making sure all necessary releases are signed and all providers involved in the person system of care are informed and coordinated in the way the person chooses.

NOTE 2:
If the referral does not fit criteria for either CTI or ECC, the referral stays with ServiceLink Options Counseling/Care Transitions staff and may be revaluated for Copilot at a later date if the ServiceLink care transitions staff determine that Copilot criteria has been established.

INITIAL ENGAGEMENT, ASSESSMENT, AND ASSIGNMENT

CTI: Process Steps by Copilot Referral Coordinator if referral is from a hospital

1. If referral is from hospital meets CTI criteria (see chart above), Copilot Referral Coordinator meets with patient while they are still in the hospital to explain Copilot program and reason for the referral. (If patient/client has already discharged, Copilot Referral Coordinator contacts patient/client by phone and home visit to explain Copilot and reason for referral).
2. If person wants Copilot CTI, then Referral Coordinator has patient/client sign the Copilot Consent form and begins process of engagement with patient including beginning to explore interests and options and documenting client information in Refer.

3. Copilot Program Lead reviews CTI Care Coordinator Case Loads with Copilot Referral Coordinator and recommends assignment with CTI team, confers with team, and confirms assignment within a week of referral (I THINK THIS SHOULD CHANGE TO SAY WITHIN THREE BUSINESS DAYS).
4. Once clients is assigned to a Care Coordinator, the Referral Coordinator and the Care Coordinator arrange a warm handoff designed to maintain engagement with client. Ideally this would happen when patient is still in the hospital but could also happen via a home visit.
5. Copilot Referral Coordinator will document assignment to Care Coordinator in Refer 7 and incomplete referral electronically to identified Copilot Care Coordinator and will transfer client/patient file to Copilot Care Coordinator.
6. Copilot Referral Coordinator will document assignment to specific Copilot Care Coordinator in data tracking sheet and will update Copilot Care Coordinator client caseload tracking sheet.

ECC: Process Steps by Copilot Care Coordinator if referral is from the clinic or a partner

1. If referral is an ECC referral from either the clinic or a partner organization such as MFS or ServiceLink, Copilot Referral Coordinator calls the client, explains Copilot and reason for the referral, and ask if they consent to referral.
2. If person verbally consents to Copilot ECC, then Copilot Referral Coordinator meets with client either in the office or at their home and has patient/client sign the Copilot Consent form and begins process of engagement including documentation of basic screening information including the LTSS screening and Copilot ECC short Person Centered Planning Assessment.
3. Copilot Program Lead brings referral to weekly Copilot Team meeting for review, acceptance and assignment to an ECC Care Coordinator.
4. Once clients is assigned to a Care Coordinator, the Referral Coordinator and the Care Coordinator arrange a warm handoff designed to maintain engagement with client.
5. Copilot Referral Coordinator will document assignment to Care Coordinator in Refer 7.
6. Copilot Referral Coordinator will document assignment to specific Copilot Care Coordinator in ECC data tracking sheet.

CARE COORDINATOR STEPS ONCE REFERRAL IS ASSIGNED

Meeting with Client

- Have client sign **Copilot Consent form** (if not already signed).
- Get **Releases of Information** Signed between Copilot and any organization or program that the client is willing to have us talk with on their behalf.
- Provide **Copilot One Page** to client and review, answer client questions about program.
- Complete **Options Counseling Assessment**-completed for each person whether ECC or CTI, include this in the individual client file as well as Refer 7 if the client is CTI.

- Develop **CTI or ECC Phase Plan.** This should be uploaded and attached to the Refer 7 client file. For ECC this will be kept in accordance with MFS procedures.
- Schedule next appointment. For CTI Care Coordinators, use follow up function in Refer to document all referrals made to other programs and to document next appointment as a follow up. **Staff Ongoing Meetings with Client**
- Discuss with client his/her goals and complete a **CTI Phase Plan, if CTI**-this may take several meetings before client can identify his/her goals.

CTI
Frequency of meeting with client

- **Pre-CTI**-staff meets client while he/she is still in hospital (if applicable).
- **CTI Stage 1**-Staff meets weekly w/client for 3 months, completes **CTI Progress Note** for each meeting.
- **CTI Stage 2**-Staff meets bi-weekly w/client for next 3 months, starts making referrals and helps client connect with referral sources, completes **CTI Progress Note** for each meeting.
- **CTI Stage 3**-Staff meets monthly w/client for next 3 months, phone calls in between, completes **CTI Progress Note** for each meeting.
- **End of Stage 3**-Completes **CTI Closing Note.**

ECC
Frequency of meeting with client –
This will be determined by Care Coordinator and the client based on client needs and wants

- Staff meets with client and provides a copy of **Copilot One Page**, answers any questions client may have.
- Staff has client sign **Consent Form**, if not already completed.
- Staff has **Releases** signed.
- **Options Counseling Assessment**- and a care plan for each enrolled patient, updated on a regular basis.
- **ECC Progress Note**-completed for each client meeting.

ADDENDUM

ServiceLink/Copilot Referral Coordinator Parameters Based on care transitions role established between ServiceLink and CMC-DHK:

- ServiceLink Care Transitions Referral Coordinator sends email to: 1) CMC-DHK social work staff for onsite hours for upcoming week on Fridays; 2) DHK Care Coordinator staff regarding onsite availability.
- Check E-Discharge for new referrals of communications from CMC staff every morning (M-F) from the office.
- Go to hospital every morning (M-F) in the am to check in with social work staff hour and if there are patients to see right away stay and see patients (timeframe onsite at CMC-DHK 9:30 am to noon (timeframe may vary depending on need).
- If unable to see patient while the patient is in the hospital – call once discharged, explain how referral was received, and ask if it's ok to follow up. (May want to send one page write up of care transitions to patient by e-mail or snail mail.)
- Communicate regularly through e-discharge about steps; also use spread sheet as a way to track patients and communicate when on site; let CMC-DHK staff know time frame that you plan to be there – every morning at a regular time for a couple of hours is probably best; let them know when you will be away or not able to be there
- List of CMC-DHK staff to check in with regularly by email and or in person will be updated regularly.
- Coordinate with Conifer, Genesis, and other onsite staff as possible.

COPILOT Form Enhanced Care Coordination (ECC) Program Consent

What is the Copilot ECC program?

Copilot is a grant funded collaboration with Cheshire Medical Center/Dartmouth Hitchcock, Monadnock Family Services and Monadnock Collaborative's ServiceLink program. Copilot is a voluntary participation, person centered project that supports individuals with complex needs to meet their goals. It is a limited time enhanced care coordination program designed to be the "copilot" for the individual to assist with supports, services, referrals and more. Copilot is designed to empower individuals with complex needs to ensure that the person has well established connections and resources for better outcomes. The Copilot ECC Program is a time limited practice with five to six (5-6) months of gradually-decreasing support. Your Care Coordinator will meet with you regularly to assist you in meeting some of your goals in that time frame.

Why were you referred to the Copilot CTI Program?

You have been referred because you are Medicaid eligible and in a challenging period in your life. Additionally, you may need help in coordinating services related to housing, home and community based services, healthcare services and support from your family and friends. If you decide to participate in the Copilot Program, your Care Coordinator will go over this consent form with you and answer any questions that you may have.

What are the benefits of participating in the program?

There is strong evidence to suggest that there are multiple key benefits of participating in an enhanced care coordination program such as reduced hospital and ER admissions, enhanced community connections, better navigation of community resources and services as well as an improved ability to manage one's own needs by the end of 5-6 months.

What about confidentiality?

The Copilot Program will conform to all NH state and federal HIPPA compliance rules and laws. Your consent means that you are participating in the project and allow Monadnock Family Services (MFS), Monadnock Collaborative (MC) and Cheshire Medical Center/Dartmouth Hitchcock Keene (CMC/DHK) to share your information to best suit your needs and goals. You may be asked to sign additional consent forms with other community partner organizations if you and your Care Coordinator find it helpful for your goals and needs.

Who can I contact for information about this program?

Name of Care Coordinator: _____Phone number: _____

You are free to decline to participate in this project or to withdraw your consent and discontinue participation in the project at any time.

Consent

Name (Please print): _____

Address: _____

Phone number: _____Other contact person: _____ Phone: _____

My signature below indicates that I agree to participate in the Copilot ECC Program as described above.

_____ _____

Signature of participant Date

DRAFT

Copilot Program

A collaboration between Monadnock Family Services, Monadnock Collaborative & Cheshire Medical Center-Dartmouth Hitchcock Keene

Client Closure Form

Please fax to: ServiceLink/Copilot Referral Coordinator at fax #:603-352-8822. Office contact phone (603)352-7707.

Referral date: _____ *ECC client*_____ *CTI client*_____ *Closure date:*_____

Care Coordinator's Name: _____

_____

Client/Participant name: _____ DOB: _____

Address: _____

Phone number: _____ Email: _____

Alternate Contact Person: _____

Client understands that he/she has been closed to the Copilot program. ☐ Yes ☐ No

Reason for Closure (check all that apply):

☐ Client is closed due to non-engagement (after one month of calling, stopping by, e-mail have not heard or made contact)

☐ Client has personally terminated his/her participation (client asked to be removed from the program) Please explain:

_____

☐ Client has successfully completed the program (client is graduating)

☐ Client is ready for traditional case management

☐ Client is now receiving services from MFS Case Management or other services. Please describe:

_____

☐ Client is receiving CFI Case Management. Agency and case manager:

_____

☐ Client is receiving other supports and services. Please explain:

_____

☐ A closure letter was sent to client on: Date: _____

☐ Any additional information regarding client: _____

_____

_____

Date this form was faxed to Copilot Referral specialist: _____

Copilot Program

A collaboration between Monadnock Family Services, Monadnock Collaborative & Cheshire Medical Center-Dartmouth Hitchcock Keene

Copilot Care Transitions Intervention (CTI) Referral Form

Please send referral via E-Discharge OR Fax completed referral and consent form to:
Copilot CTI at FAX # 603-352-8822. To contact Copilot by phone call 603-352-7707

Referral date: _____ *Referral source name:* _____

Referral source phone number and email: _____

_____

Reason for Referral (*What improvement are you hoping) for?)*_____

Client name: _____ DOB: _____ Male ☐ Female ☐

Address: _____Phone number: _____

_____

Primary Mental Health Diagnosis: _____

Primary Medical Diagnosis: _____

MUST meet ***ALL*** requirements

☐ Referral was *discussed* with client and the client wishes to participate

☐ Client is 18 +

☐ Client is a resident of Monadnock Region (circle town): *Alstead, Achusiot, Chesterfield, Dublin, East Swanzey, Fitzwilliam, Gilsum, Harrisville, Hinsdale, Jaffrey, Keene, Marlborough, Marlow, Munsonville, Nelson, North Walpole, Richmond, Rindge, Roxbury, Stoddard, Sullivan, Surry, Swanzey, Troy, Walpole, West Chesterfield, West Peterborough, West Swanzey, Westmoreland, and Winchester.*

☐ Medicaid (Must have Medicaid or be applying and likely eligible for Medicaid to receive Copilot services.)

Client is being discharged from: *(check one box)*

☐ A New Hampshire Hospital (NHH) adult inpatient unit to a physical address in IDN catchment area.

☐ CMC-DHK Emergency Room

☐ CMC-DHK (discharged to the community or skilled nursing facility)

☐ Other Hospital Facility _____

Send the Following Documents:

☐ Consent for Copilot ☐ Evaluation (IEA if applicable) ☐ Copilot Referral Form

☐ Hospital discharge summary and discharge orders

Current areas of unmet need (requirement of 3): Housing ☐ MH/SA treatment ☐ Medical or Mental Health service coordination ☐ Money Management ☐ Family Intervention ☐ Money mgmt. ☐ Daily Living Skills ☐Other

For Copilot Use:
Received Date: _____ CTI Referral Coordinator Contact Date: _____ Eligible: Yes ☐ No ☐

If not eligible, referred to IDN Provider(s):_____

COPILOT PROGRAM
RELEASE OF INFORMATION
Monandock Collaborative
105 Castle Street, Keene, NH 03431

Copilot Participant's name: _____ DOB: _____

Address:

Phone number: _____ Email: _____

I, (client) _____, grant permission to the

Copilot Program to obtain my personal information from the following organizations,

- ☐ Medical provider_____
- ☐ Mental Health provider_____
- ☐ Housing organizations _____
- ☐ NH Department of Health and Human Services
- ☐ Social Services Agencies _____
- ☐ Financial Institutions _____
- ☐ Family member *please list name(s)* _____
- ☐ Friends *please list name(s)* _____
- ☐ Other *please list* _____

for the purpose of providing effective case management services. I also give permission to the Copilot Program to exchange any and all information in my Medicaid record for my medical, financial and social services needs.

The duration of permission is effective from _____ to _____

I also understand that my Copilot Care Coordinator, _____ will be my point person for the duration of my Copilot participation.

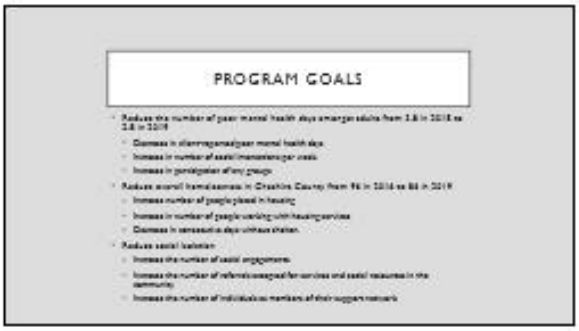
_____ _____
Signed by the Copilot participant Date

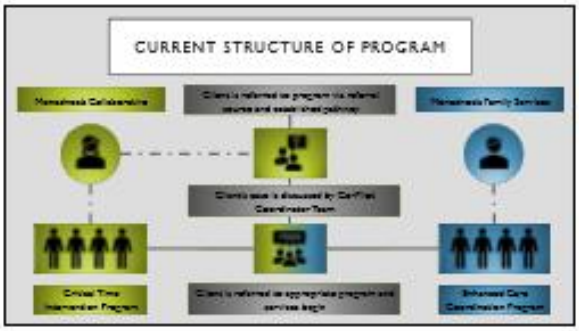
_____ _____
Printed name and signed initials of Copilot Care Coordinator Date

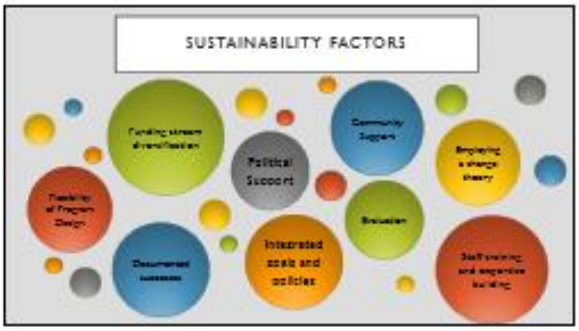
As the team operationally plans for transition from DSRIP waiver funding both organizations report tremendous value in the programs for their clients. However, the current payment landscape may not be able to support the program's sustainability fully. Both teams are currently drafting a business plan for the program post 12/31/20 and conducting analysis on how this work may overlap other initiatives within their organizations. As they synthesize their findings, with support of the IDN1 team there is the intention to propose sustainability efforts for the hired positions and assist the team in pursuing funding that will help preserve the programs. The Co-Pilot team throughout the fall of 2019 worked with the quality improvement coach to develop a sustainability plan and roadmap for this planning. The team met to review the framework and they will now focus on building out the content. Below is the framework that was developed.

CO-PILOT PROGRAM SUSTAINABILITY

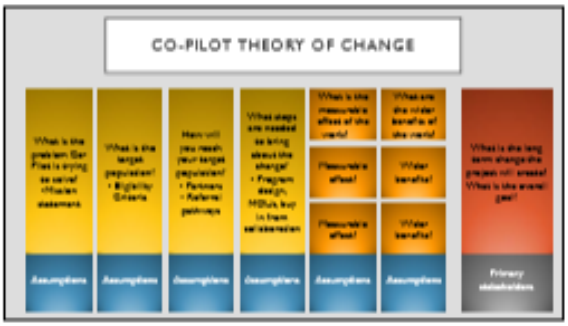
PROGRAM OVERVIEW

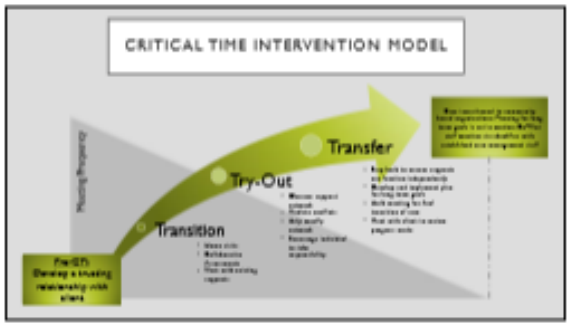

PROGRAM GOALS

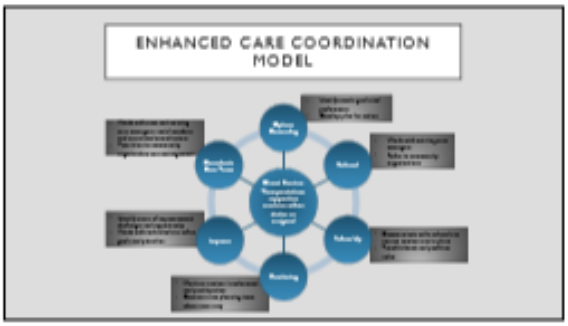

CURRENT STRUCTURE OF PROGRAM


SUSTAINABILITY FACTORS
Funding stream diversification
Political Support
Community Support
Employing a change theory
Flexibility of Program Design
Documented successes
Integrated goals and policies
Evaluation
Staff training and organizational building

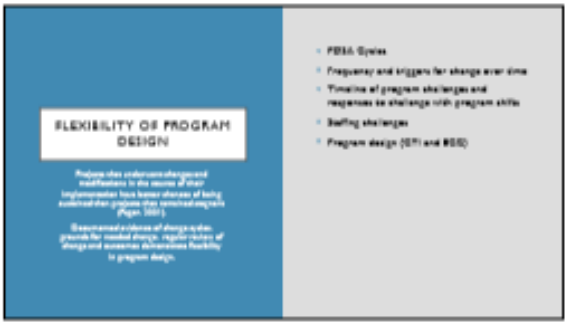
EMPLOYING A CHANGE THEORY


CO-PILOT THEORY OF CHANGE

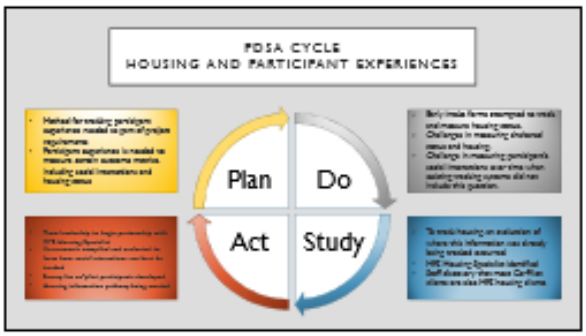

CRITICAL TIME INTERVENTION MODEL
Transfer
Try-Out
Transition


ENHANCED CARE COORDINATION MODEL

DOCUMENTED SUCCESS AND DISSEMINATION

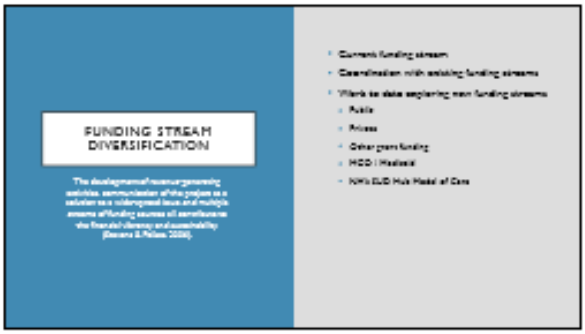

FLEXIBILITY OF PROGRAM DESIGN

PDSA CYCLE
TEAM LEADER POSITION
Plan
Do
Act
Study


PDSA CYCLE
HOUSING AND PARTICIPANT EXPERIENCES
Plan
Do
Act
Study

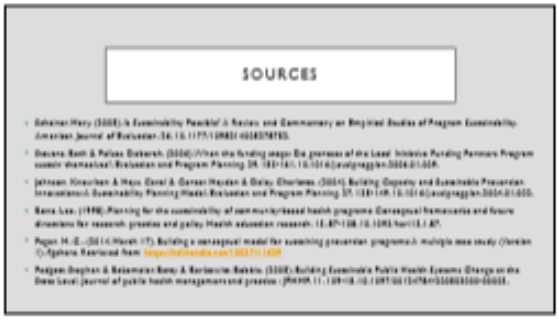
STAFF TRAINING AND EXPERTISE
Training plan
Changes to training plan
Cross training

CO-PILOT TRAINING PROGRAM
Insert CarePlus Training Plan


FUNDING STREAM DIVERSIFICATION
Current funding stream
Coordination with existing funding streams
Work to date exploring non funding streams
Public
Private
Other grant funding
HCO / Medicaid
NH's ELD Hub Model of Care

EVALUATION
Reporting – regular and enhanced over time
New measurements developed?
Procedure for evaluation of data
Effectiveness of project over time

DATA REPORTING OVERVIEW
Frequency of reporting
Structure of reports and data sources
Review and feedback loops
Program changes derived from



The Co-Pilot team has continued to attend the Community of Practice sessions offered by the CACTI faculty. With the renewed contract to provide the quarterly learning meetings, the team plans to continue attending and hopes to be able to leverage other sustainability planning throughout the state.

The co-pilot team continues to capture data on Co-Pilot participants by quarter and referral tracking. The team will look to use this data to continue to improve efforts as they have a fully staffed team. Reflected in the table below is a substantial increase in active participants, this is due to having a fully staff team and a more efficient workflow. Additionally, because the team underwent revamping the CTI process due to the fidelity training, there graduate reporting is reflecting quarter by quarter oppose to cumulative.

Copilot Participants						
Year 2	Q1: 7/1-9/30/18	Q2: 10/1-12/31/18	Q3: 1/1-3/30/19	Q4: 4/1-6/30/19	Q5: 7/1-9/30/19	Q6: 10/1-12/31/19
Active Participants	27	*30*	*28*	*^26*	*39 CTI* *15 ECC* *54 Total*	*36 CTI* *12 ECC* *48 Total*
Pre CTI		1	1	2	11	5
Participants CTI Phase I	0	2	6	9	13	9
Participants CTI Phase II	7	0	2	8	16	9
Participants CTI Phase III	5	8 (4 of these ended CTI phase 3 in December)	2	4	10	13
Participants ECC	15	19	19	^3	15	12
# of Completed Participants to Date	11	15	21	23	11 CTI Closed (Participants were closed due to non-engagement; or to align with CTI fidelity model best practices. 2 ECC (1 died; 1 consumer request)	4 additional CTI Graduates 1 CTI person died during phase 2. (choose to go off medical treatment)
Total Number of Referrals from CMC-DHK		12 (7 CTI, 5 ECC)		16 CTI (2 declined)	24 CTI from CMC-DHK 8 ECC (3 DHK; 3 MFS; 2 ServiceLink)	12 CTI
Total Declined by Team		6 (Primarily due to Insurance elig.)		No CTI declined	1 CTI 0 ECC	2 CTI
Total Assigned but not engaging after 30 days					2 CTI	1 CTI

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

7. The Copilot program has helped me become more involved in my community. (Examples: Sometimes I attend church, I attend peer support groups, I go to my appointments, I visit with others.)

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Comment:

8. I am better able to take care of my daily needs since being in the Copilot program. (Examples, bathing, taking medication, eating, going to appointments).

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Comment:

9. What is your first name?

10. What is your date of birth?

Date / Time

MM/DD/YYYY

11. Since starting Copilot my poor mental health days have:

- increased
- decreased
- stayed about the same

12. How many poor mental health days did you experience in the 60 days PRIOR TO starting Copilot?

0 60

3

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 has 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.

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. The team continues to review metrics to ensure data capture which contributes the improvement of the program as well as ease of tracking.

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 Project Manager 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.

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				
Reduce the number of poor mental health days amongst adults from 3.8 in 2015 to 2.8 in 2019 (source: County Health Rankings)	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	**13/30 Responded** 11 of 13 reported a Decrease
Indicator 2: Increase in number of social interactions per week			N/A	8 of 13 reported an Increase
Indicator 3: Increase in participation in any groups (social, religious, self-help, public service, etc.)			N/A	**19/30 Responded** 14 of 19 replied Do not agree/disagree
Reduce overall homelessness in Cheshire county from 96 in 2016 to 86 (source: NHDHHS-County Level Information)				
Indicator 1: Increase in number of people placed in housing			5 out of 14	5 of 14 respondents homeless at time of referral- 3 additional have been housed
Indicator 2: Increase in number of people working with housing services			12 out of 14	Increase of 5
Indicator 3: Decrease in consecutive days without shelter			N/A	No reported decrease
Reduce social isolation (source: GMPHN Community Survey)				
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	18 reported agree or no change
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	This measure has become difficult for the team to track and is revamping their collection processes

			outside of MFS	
Indicator 3: Increase the number of individuals identified as members of their support network			N/A	The team has agreed that this Indicator is too subjective and there is not consistent ability to answer. The group will be reviewing and revising or eliminating this indicator
STC Defined Program Measures				
All performance measures identified within the evaluation plan milestones	100%	100%	75%	100%
Operationalization of Program				
A. Implementation of Workforce Plan				
B. Deployment of Training Plan				
C. Implementation of any required updates to clinical protocols, or other operating policies and procedures				100%
D. Use of assessment, treatment, management and referral protocols	100%	100%	100%	
Initiation of Data Reporting				
A. Number of individuals served vs. projected			N/A	58 /86
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected			100%	100%
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	100%	100%	100%	100%

The team continues to 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.

In the fall/winter of 2018 the team created and distributed a client survey (below). The survey was based on the Serve Community Treatment Scale (Denver, CO). The purpose of the survey is to garner feedback and capture project defined patient measures. The team has planned to distribute the surveys every six months, however given the unique nature of the program and the ability to follow-up with clients once they have existed the system. The team is determining the best approach to consistent survey evaluation.

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	Staffing on 6/30/19	Staffing on 12/31/19
Care Transition Coordinators	2 FTE	0	2 FTE	2 FTE	1 FTE, 1 Recruit to Hire	2 FTE	2 FTE
Enhanced Care Coordinators	2 FTE	0	2 FTE	2 FTE	2 FTE	2 FTE	2 FTE
Supervisor	.1 FTE	0	.1 FTE	.1 FTE	% of Time being Adjusted	.2 FTE	.2 FTE
Referral Specialist	-	-	-	-	-	.15 FTE	.15 FTE

- Over the course of the past reporting period the team experienced one position turn over. They were able to quickly replace and train the position, ensuring that the teams remained high functioning. The teams continue to use their robust onboarding plan to ensure everyone is aware of the models and workflows.

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 Actual	CY 2019 January to June Actual	CY 2019 July to December Projected	CY 2020 Projected
Total Salary/Wages		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Employee Benefits		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Supplies (Technology etc.)		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Travel		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Recurring Expenses		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Marketing/Communications		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Staff Education and Training		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Subcontracts/Agreements(see one time expenses)		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
One Time Expenses		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total:		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Off-setting Revenue		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total Expenses - Revenue		$ 83,823.03	$ 107,661.00	$ 74,196.51	$ 84,484.80	$ 81,471.52	$ 193,323.00

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 (Y/N)	Project Affiliation
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 continues to work on streamlining efforts of screening as the B1 work between MFS and CMC continues to develop.

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
Intake and Triage Form , Survey Tool	Team Developed- Based off of evidence based tools
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 December 31, 2019:

The Co-Pilot team continues to refine and adjust their protocols as needed. See details below for current practices:

Existing Patient Flow Process: (See Patient Process flow above) The Co-Pilot team with the support of IDN project management continued to revise their process flows from referral, engagement and progress through the programs. With the division of work between the Monadnock Collaborative and Monadnock Family Services, the process flow was updated (see document above in narrative updates). Additionally, through PDSA cycles they look to refine and streamline their forms and protocols to ensure efficiency for the staff and better patient experience. The team now reviews referrals at their monthly meeting, and when the opportunity is available, the assigned case manager receives a warm-handoff. The team continues to work through the challenge of a case manager being out with a client in the community at the same time a patient may be ready for discharge. 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 team has improved the tracking of their referral form improving their data capture. 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
Phil Wyzik	CEO at MFS: Serving as the lead fiscal agency for the C1 Proposal, Additional 40 hrs. per year contribution
Maryanne Ferguson	CEO at Monadnock Collaborative: Serving as the housing agency for CTC Positions, Additional 40 hrs. per year contribution
Jen Seher	Program Director at Monadnock Collaborative: Supportive role for CT Coordinator Positions, Additional 40 hrs. per year contribution
Eileen Fernandes	Chief Program Officer at Monadnock Family Services: Provides oversite and support for program. 40 hours per year contributed.
Dr. Andy Tremblay	Director of Primary Care at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
Tiffany French, RN	Nursing at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
Lorraine Bellows	Co-Pilot Referral Coordinator
2 2	CTI Coordinators ECC Coordinators

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. The team also continues to be actively involved in available CTI trainings, and hosted a CTI training at their site for new members. They will attending the CTI fidelity training in July 2019 which supported the improvement to their work. The team has created an outline training tool see below:

Key to Trainings

IT/IS

- Refer
- MFS EMR
- KNO2
- CMC-DHK EMR

MFS Specific

- ANSA Certification = ANSA
- MFS Orientation = MO
- Intake/Triage Assessment = Triage

CTI Model

- CTI (initial and ongoing community of practice) = CTI
- CTI trainer = CTI+

ADRC/NWD Specific

- Person Centered Options Counseling Certification = PCOC
- AIRS Certification = AIRS
- SLRC Orientation = SO

CMC-DHK

- HR and Onsite Orientation = CMCO

Copilot Specific

- Referral and Intake Process – CP1
- Copilot Workflow = CP2
- Assessment and Follow up Assessments = CP3
- Tracking and Reporting = CP4

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				
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

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

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.

Current State Updates from July – December 2019:

During the semi-annual period the PATP-IOP Expansion project team continued to hold project meetings once monthly in person. As the team continues to work towards sustainability and process improvement, the IDN1 team has slowly withdrawn project management and facilitation involvement. The PATP-IOP has not received support from a CHI QI coach since the 2019 New Year. The IDN Medical Director is attending meetings regularly providing ongoing relationship connections and feedback for the IDN administrative team. During this semi-annual period the PATP-IOP was fully staffed with the exception of a .2FTE effort. This was a result of the contracting process in which the IDN administration renewed the project contract through the end of 2020. The team is continuing to pursue ongoing team training. As the team enters that last year of implementation, there is direct focus on sustainability. They are currently developing a business plan and working internally to discuss support from a system perspective. The IDN administrative team also is having ongoing discussions on how we can help support their payment needs on the state level. The program has been operating at full capacity and has shown value in improving the quality of life in the patients they treat. The IOP has been continuously seeing patients.

- Program Handbook Last updated November 2019; Treatment Agreement updated October 2019
- Program schedule – currently provide 9 groups per week including IOP; have adjusted group schedule to meet participants' needs
- Created and implemented a new Recovery Workbook
- Doubled the amount of food supplied by the Haven
- Work collaboratively with child protection in both states including Safe Babies court teams
- Work collaboratively with NH probation and drug court
- Staff Trainings:
    - All staff attended Circle of Security Training
    - Several staff attended Moral Recognition Therapy and DBT training
- Recovery Friendly Practice presentations @ University of Vermont, Leaders in Education for Neurodevelopment Related Disabilities
- New England Perinatal Quality Improvement Network Presentation
- How to avoid your own behavioral health crisis when caring for that of your patient

- Women, Infants, Children (WIC) Presentation
- New Hampshire Behavioral Health Summit Presentation
- Marce of North America Presentation
- Northern New England Perinatal Quality Improvement Network Presentation
- New Hampshire Psychiatric Society Annual Meeting Presentation
- Northeast Regional Psychiatric Nursing Conference Presentation
- Implemented on site dental services
- Integrated Infectious Disease Fellow has provided education and on-site hepatitis C treatment and is in process of gearing up for a Sexual Health Clinic
- Both NH and VT on-site WIC clinics established
- Continuing to refine treatment plans for women who are unable to stop using substances at IOP level of care or may be disruptive to other group members

- Continued expansion of referral sources and enrollment of participants for the PATP/IOP
- Trauma-informed Yoga offered in IOP
- Seeking opportunities to include blood draws on site
- Now have RN support available for injectable medications and support for women's health services
- Continue to assess social determinants of health for all IOP participants
- Continue to collect outcome data on all program participants

Some completed work from July - December, 2019:

Newly developed Recovery and Wellness Work-Book (description):

The Recovery and Wellness Work-Book we have begun implementing with patients was created by Justin Wardell, CRSW and Cheri Bryer. Our workbook consists of three parts. The first part of the workbook details how to develop goals in areas such as connection to recovery community, physical health, emotional health, goals related to employment, etcetera. The formatting of this section of the workbook has been based on the Recovery Wellness Plan created by CCAR (Connecticut Community for Addiction Education) in 2013. This portion has been incorporated into our workbook to help encourage patients to set realistic smart (Specific, Measurable, Achievable, Realistic, Time-Bound), goals. Setting small specific goals and reaching them can help empower patients to continue taking further action in their recovery.

The second section of our workbook explores practices in relapse prevention. There are a variety of exercises to help patients explore what relapse prevention means in their lives. These exercises include exploration of high risk situations, healthy sober supports, and what causes one to be triggered. These relapse prevention exercises have been written and created by Justin Wardell, CRSW.

The last portion of our workbook is based on exploratory projects for the patient and topics for discussion between the recoveree and recovery coach. The discussion topics consist of a few sentences outlining the specific topics. These sentences are written in a way to encourage dialog between the recoveree and recovery coach. The topics in this section include resentments, learning to place our needs first, value based decision making, dealing with boredom, and control. The projects in this section are ones to help the reader explore

the underlying needs we were trying to depress by using substances/alcohol. These projects include goodbye letter to your addiction, time capsule project (Describing what your life may be if you continue a life in recovery), and a gratitude list.

In conclusion, our book has been made with the hope that individuals can begin working towards their individual goals, and learn more about their individual addictions. No matter how far one has come in their recovery, there is always room to grow. We hope this workbook will help to meet individuals where they are at.

Updated Patient Handbook:

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. Moms in Recovery is a safe place for women who have substance use disorders to get support for building healthy, satisfying lives that are free from active addiction.

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

Leah Abrahamsen, MSW, LICSW *therapist*

David Bae, MD, *Addiction Psychiatrist*

Cheri Bryer, *Recovery Coach*

Steven Chapman, MD, *Pediatrician*

Martha Dickinson, MA, *Playtime Coordinator*

Julia Frew, MD, *Medical Director and Addiction Psychiatrist*

Daisy Goodman, CNM, *Nurse Midwife, Director of Women's Health Services*

Stephanie Gray, Administrative Coordinator

Judy Knapp, *Administrative Assistant*

Teri LaRock, MSW, LICSW, Clinical Director and *Therapist*

Lucy Reynard, MSW, LICSW Therapist

Linda Snow, BA, *Resource Specialist*

Tonya Suarez, MSW, LICSW, *Therapist*

4. 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.

5. 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
- Playtime family support program for children of women in recovery
- Diaper bank
- Donated maternity and infant items

6. 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.

7. 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.
- Individual treatment planning that meets your specific treatment needs.
- 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)

8. 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 but are not limited to (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, or (e) significant threats to self, others or property.

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. Photos of members or member's children at the program are not allowed. 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/

9. 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.

- Respect of other participants individual treatment plans, each one is unique to her own treatment goals.
- 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.
- 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 to include their children 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 or staff member 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/vaping is prohibited near the doors of the Addiction Treatment Program and in the courtyard.

10. 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.

11. 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.

12. Group Schedule (subject to change)

Outpatient Program

Monday:

11:00 -12:15 Healthy Relationships and Interpersonal Effectiveness

12:30-1:45 Motivational Enhancement and Relapse Prevention

Wednesday:

10-11:15 Pregnancy Group; Motivational Enhancement and Relapse Prevention
11:30-12:15 Health Education
12:30-1:45 Postpartum Group Motivational Enhancement and Relapse Prevention

4:00-4:55 Motivational Enhancement and Relapse Prevention

Friday:

11:00-12:15 Motivational Enhancement and Relapse Prevention

Intensive Outpatient Program

Monday

9:30-10:00 Testing and writing/journaling

10:00-11:00 Check In

11:00-11:15 Break

11:15-12:30 Healthy Relationships

Wednesday

9:30-10:00 Testing and writing/journaling

10:00-11:15 Motivational Enhancement and Check In

11:15-11:30 Break

11:30-12:30 Health Education and provider appointments as indicated

Friday

9:30-10:00 Testing and writing/journaling

10:00-10:45 Mindfulness/Yoga with Holle or Recovery Wellness with Cheri

10:45-11:00 Break

11:00-12:30 Relapse Prevention, Safe Weekend Planning and Check Out

*With the exception of start and end times, 9:30-12:30, schedule is approximate and subject to change.

13. 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 (ie 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 will 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. Treatment is most effective when you participate.

The Moms in Recovery Program believes it is important you are open and honest and respectful 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.

14. Playtime and Children in Groups

We want every mom to have a safe space to leave her children while she attends treatment. While moms are welcome to bring their newborn babies into group, we also encourage moms to become familiar with our Playtime offering, especially when babies have moved into a more

active stage of their development. During group sessions, women need the chance to focus on themselves for several hours. If a baby is very fussy, active, or noisy, the distraction can interrupt the group, and we recommend mothers take their child out of the group room until s/he is once again calm. Our Family Support and Volunteer Coordinator is happy to talk with any mom about "Playtime" and welcomes prospective mothers as well as mothers with babies or young children to visit the play space. While initial separation from mom can be challenging for mother and child, our approach to introducing children to "Playtime" includes brief visits at first, minimizing the anxiety for both mother and child. As a child becomes familiar with the play space and the stimulation of other children and adults, the length of a child's presence can be gradually increased.

15. Recovery Coach

Members of the program have the opportunity to and are encouraged to work with the recovery coach. The goals of recovery coaching are to promote recovery, remove barriers, and connect women with recovery support services and to encourage hope, optimism and healthy living. The recovery coach will work with you by listening to your experiences, advocating for your improved health and providing you with honest feedback regarding self-destructive patterns of thinking, feeling and acting. The recovery coach is part of the clinical team and will share information with other team members as necessary as it relates to substance misuse, unsafe behavior and safety concerns.

16. The Parent Education Program

We recognize that substance use disorder impacts your family and in conjunction with a formal parenting education group we are available to offer support based on your individual parenting goals.

We offer a parent education group several times a year. It is 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. Circle of Security is a program that helps parents develop a secure, healthy attachment with their children. The program lasts for nine 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

17. Pathway through Treatment

Many 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 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.

18. Urine Drug Testing

- All program participants will provide a 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.

19. 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 or report using a substance such as opiates, marijuana, 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 a substance two weeks in a row (that are not prescribed to you), we may refer you to a higher level of care. This could be the Intensive Outpatient Program (IOP) or it could be a residential treatment program. If you enter the Moms in Recovery IOP you are supported within the first 2-3 weeks to stop use of

non-prescribed substances and if unable to get stopped you may be referred to a higher level of care, referred to another program or offered a taper. In some cases you may be offered three to four weeks of individual sessions of motivational enhancement therapy to prepare to re-enter the intensive outpatient program.

Marijuana/Alcohol

Moms in Recovery is an abstinence-based program. That means that we ask participants to remain abstinent from all mood-altering substances, including marijuana and alcohol. The use of alcohol while taking buprenorphine is very dangerous and potentially deadly. Patients will be tested periodically for alcohol; lack of cessation may result in inability to receive a prescription for buprenorphine. There is growing scientific evidence that marijuana is not safe to use while you are pregnant or breastfeeding. We believe that marijuana is not safe for anyone who has a substance use disorder because it increases vulnerability to relapse.

We recognize that stopping marijuana use is a difficult process for some people who have been using it for a long time. We will provide you with information about marijuana and alcohol use and how it can impact your recovery during and after pregnancy as well as strategies to help you quit and stay stopped. Women who are testing positive for THC are not eligible to be on a "maintenance schedule".

20. Child Protection Communication

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. Participation in treatment can help improve 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. Please understand that each individual family situation is unique as are the processes in different states. Please speak with a clinician if you have concerns or questions about child protection involvement or communication. The treatment team will do their best to help support a participant through this process and advocate on your behalf.

21. 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.

22. 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.

23. 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.

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 – June, 2019 continued 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. 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 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

Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet	Accountability of Time: Met or Unmet	Participation in IDN Activities: Met or Unmet
Q4 Y2: October 1, 2019 - December 31, 2019						
"PATP-IOP" Dartmouth Hitchcock	*Milestone 1*: Documented efforts of securing sustainable funding	Ongoing	Met/ ongoing	Met	Met	Met
	Milestone 2: Collect and Interpret Outcome Data	Quarterly Submission	Met			
	Milestone 3: Share Continued Efforts for Program Improvement	developed/ updated materials	Met/ ongoing			

This evaluation table is used in conjunction with the on-the-ground support and assessment conducted at monthly 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	As of 6/30/19	As of 12/31/19
Number of Medicaid women successfully completing the IOP program		Program Not Started	N/A	7	13	19
Number of women engaged in continuing care one month following completion of IOP			N/A	7 (All require other level of care)	8	15
Number of negative UDS at end of program			N/A	2	10	19
Number of women receiving reproductive health services visit			89%	100%	13	98%
Number of pregnant women who attend recommended prenatal visits during program			100%	100%	100%	100%
Number of women with established PC relationship			78%	58%	43%	53%
All program participants are screened for SDoH			78%	89%	82%	81%
STC Defined Program Measures						
All performance measures identified within the evaluation plan milestones	100%	100%	100%	100%	100%	100%
Operationalization of Program						
A. Implementation of Workforce Plan						
B. Deployment of Training Plan						
C. Implementation of any required updates to clinical protocols, or other operating policies and procedures						
D. Use of assessment, treatment, management and referral protocols	100%	100%	100%	100%	100%	100%
Initiation of Data Reporting						
A. Number of individuals served vs. projected			75%	75%	75%	75%
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected			100%	100%	100%	100%
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	100%	100%	100%	100%	100%	100%

Details of the Reporting Measures: July - December, 2019

PATP-IOP Expansion Program Performance Measures	**Cumulative to 9/30/19**	**Cumulative to 12/31/19**	**Notes**
1) Number of women successfully completing the IOP program	16	19	Completion defined as: 22 sessions completed within an 18 week period

Number of women enrolled	5	4	
Number of women discontinuing program prior to completion*	19	22	*Each IOP treatment episode is reported separately;
If discontinuing program, disposition:			
Office based treatment	6		Does not include patients with ITP due to not group appropriate
Residential treatment recommended, treatment status unknown	8	10	
Residential treatment confirmed	3	4	One person attended 28d, then longer duration
No known treatment on discontinuation of program	6	2	
2) Number of women engaged in continuing care one month following completion of IOP	15		*Measure specifies **after completion of IOP**
o Continuing Care is:			
§ Return to OP level of care at Moms in Recovery	11	3	Includes one patient who discontinued IOP early
§ Transfer to other OP or IOP	2	0	incudes patient who discontinued IOP early
§ Discharge to higher level of care	2	1	
3) Number of women with negative UDS at end of residential program*	17	19	
o Less than 50% testing positive for THC by the end of an IOP	24%	26%	Indicates % positive for THC
o Less than 25% testing positive for any non-prescribed substance other than THC	46%	47%	Indicates % positive (alcohol, fentanyl, cocaine, or methamphetamine)
Following include women who discontinued, but not those currently enrolled in IOP			
4) Number of women receiving reproductive health services visit	97%	98%	
o Health Services visit includes:			
Hepatitis B screening*	43%	49%	* ordered= 97%
Hepatitis C screening*	43%	49%	* ordered= 97%
HIV screening*	43%	49%	* ordered= 97%
Chlamydia and gonorrhea screening	70%	74%	*2 declined
§ PAP history reviewed, updated if indicated	84%	81%	* 2 did not receive recommended follow up
Had family planning discussion (OKQ)	97%	98%	OKQ= discussed pregnancy intention, offered contraception if indicated
5) Number of pregnant women who attend recommended prenatal visits during program*	100%	100%	n=8

6) Number of women with established relationship with a primary care	54%	53%	
o At least one visit with a PCP in the past 12 months	38%	40%	
7) All program participants are screened for Social Determinants of Health*	78%	81%	
o % of patients identifying concern for the following:			
§ Housing	48%	51%	
§ Financial Strain	83%	86%	
§ Education	7%	6%	
§ Social Isolation	10%	9%	
§ Transportation	72%	77%	
§ Employment	55%	57%	
§ Legal Issues	38%	31%	* **Includes legal issues known to be present for patients who reported "no" in SDOH screener (=31%)**
§ Interpersonal Safety	41%	43%	***Safety issues in past year**

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.

January – June 2019 update

As the team works to improve their project implementation, they have focused on sustainability of the program and positions. As a result the team has started to shift costs of positions internally, while still maintaining level of effort. As of 12/31/19 the team has a .2 FTE LICSW position open.

See below for quarterly submission of attestation by project team:

Attestation of Staff Time		
Current Quarter Dates:		
Name of Staff	% Time	Attest to Accuracy Y or N
[redacted]	10 %	Y
[redacted]	10%	Y
[redacted]	35%	Y
[redacted]	30%	Y
[redacted]	30%	Y
[redacted]	40%	Y
[redacted]	50%	Y
[redacted]	30%	Y
[redacted]	10%	Y
[redacted]	30%	Y

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	Staffing on 6/30/19	Staffing on 12/31/19
Masters Level clinician (BH)	1.5 FTE	Recruit to Hire	1.5FTE	1.5FTE	1.5FTE	.75FTE	1.15FTE .2 FTE Open
Psychiatry (MD, ARNP)	.3 FTE	Recruit to Hire	.3FTE	.3FTE	.3FTE	.3FTE	.1FTE
OB/GYN(ARNP, CNM)	.1 FTE	Recruit to Hire	.1FTE	.1FTE	.1FTE	-	-
Pediatrician (MD, ARNP)	.1 FTE	Recruit to Hire	.1FTE	.1FTE	.1FTE	-	-
Certified Medical Assistant	.5 FTE	Recruit to Hire	.5FTE	.5FTE	.5FTE	-	-
Case Manager	.5 FTE	Recruit to Hire	.5FTE	.5FTE	.5FTE	.4FTE	.4FTE
Recovery Coach	.5 FTE	Recruit to Hire	.75FTE	.75FTE	.75FTE	.5FTE	.5FTE
Childcare Providers	.75 FTE	Recruit to Hire	.5FTE	.5FTE	.5FTE	.3FTE	.3FTE
Administrative Support Staff	.5 FTE	Recruit to Hire	.5FTE	.5FTE	.5FTE	-	-
Data Analyst	.1FTE	-	-	-	-	-	.1FTE
Research Assistant	.3FTE	-	-	-	-	-	.3FTE

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 Actual	CY 2019 Jan-Jun Actual	CY 2019 July - Dec Actuals	CY 2020 Projected
Total Salary/Wages							
Employee Benefits							
Supplies							
Purchased Service							
Staff Education and Training							
Other: Cost							
Total							
Projected Revenue Offset							
Total IDN Funds			$55,446.40	$55,446.40	$55,446.40	$65,479.26	$125,361.92

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 July-December, 2019 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 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
ThePPATP-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 December 31, 2019:

The PATP-IOP project team went live with the IOP in early spring 2018. Having started the planning and implementation a year prior the group work diligently to produce protocol for assessment, treatment and referrals. The IOP program is now over a year and a half old with great success. The team through consistent process improvement and feedback from patients is continuing to update the protocols in place. As they

learn more from the experience and the needs of the patients the team continues to discuss the need for additional or different protocols. At this point in project implementation the team has a robust collection of IOP materials, workflows and protocols and no additional protocols have been developed.

The primary protocol components in place are listed below and additional materials used are shared below:

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
Recovery and Wellness Workbook	Workbook to support patients in developing goals and performing exercises related to their recover and wellness.	In Use

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Moms in Recovery Buprenorphine Program Treatment Contract (revised 8/2018)

Opioid addiction is a common condition that can have a devastating impact on people's health and life. We offer buprenorphine as part of a comprehensive program to help people recover from opioid addiction. Buprenorphine prevents both opioid withdrawal and opioid intoxication. When taken as a part of a comprehensive effort to restructure one's life, buprenorphine can help give people the opportunity to reclaim their lives from opioid addiction.

We offer buprenorphine as part of our addiction treatment offerings. To do so, we must make sure that we make buprenorphine available in a fashion that is therapeutically effective, programmatically efficient, and to minimize the risk of diverting prescribed medications to illegal markets. The following guidelines to help us meet these goals.

Therapeutic effectiveness guidelines:

1) Buprenorphine will be 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.
2) All patients will provide a point-of-care urine sample for a toxicology screen for substances of abuse and buprenorphine prior to receiving a prescription for buprenorphine. This urine sample may be observed by a staff member.
3) Urine samples will be periodically sent out for confirmatory testing, which may include testing for alcohol metabolites, bath salts, or other illicit substances.
4) 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.
5) The frequency of treatment visits will be determined by the treatment team. Generally patients should expect to be seen weekly for the first 9-12 months of treatment. At that point, patients who are stable in treatment (including no use of alcohol or marijuana) may decrease the frequency of visits to every other week, and eventually monthly. If drug use is reported or detected, the patient will be seen weekly again until stability is achieved.

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6) The consumption of poppy seeds in any form during your participation in our program is prohibited. Consumption will lead to a period of weekly visits, as poppy seeds can confuse our urine tests and are indistinguishable from opiate use.
7) Pregnant patients are expected to attend the weekly pregnancy group; women who are having their second or third pregnancies in our program may request to attend the pregnancy group every other week.
8) If drug use occurs while a patient is taking buprenorphine, the patient 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.
9) Patients admitting to the use of, or testing positive for, benzodiazepines, barbiturates, or alcohol will receive one written warning and sign a contingency contract. Patients 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. Patients refusing to sign the contingency contract will be given a one to two-week taper of buprenorphine and will be discharged from the clinic
10) All patients will respect the privacy of other participants in the program and will keep any information about other patients, including the fact that they attend this program, confidential. That means they will not share anything they have heard about another person in the program or anyone they have seen while attending the program to friends, family members or acquaintances. Patients will never share information about other people's treatment, including the fact that they attend this program, on social media. Violation of this guideline will result in a warning and any subsequent violation will result in dismissal.

Program efficiency:

1) We need to be able to contact patients. Patients must provide program staff with a current address and current phone number as well as an alternate phone number of someone who can reach the patient. Patients are solely responsible for keeping this information current and for keeping voicemail boxes open to receive new messages.
2) Smoking is prohibited near the doors of the Addiction Treatment Program.
3) Prescriptions will not be called in for buprenorphine preparations for individuals who miss clinic visits.
4) Patients who miss one appointment will receive one verbal or written warning in a letter sent to their home. Patients who miss a second appointment within the following 2 year period will be given a one to two-week taper of buprenorphine and will be discharged

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from the clinic. A no-show during the allotted time will be considered a missed appointment. Missed appointments need not be consecutive to result in discharge; they just need to fall within a 2 year period.

5) Patients are responsible for maintaining insurance or completing paperwork for financial assistance if they cannot afford the fees associated with care.

6) Patients who chronically overuse our support staff's time by repeatedly calling with the same issue or who call the emergency line with non-emergency concerns (such as inquiries about appointments or buprenorphine refill requests) may be discharged from the clinic.

7) Missed or refused urine drug screens are presumed to be positive for illicit substances and this will be documented in the patient's chart.

8) Program staff are mandated reporters and are required to report concerns about the abuse or neglect of a child to child protection in the patient's state of residence. Missed visits and positive urine drug screens may contribute to concern about the abuse or neglect of a child. Whenever possible, program staff will notify a patient if a mandated report is required.

9) Patients are encouraged to sign releases of information for other agencies involved in their care (e.g. DCF/DYCF, other medical providers, probation & parole, etc.). We cannot agree to provide "partial" information in these situations, such as withholding urine drug screen results.

10) Pregnant patients must present proof of pregnancy and an estimated date of delivery.

11) Staff will have one full business day (24 hours) to return phone calls and do prior authorizations.

Avoidance of diversion:

1) The total dose of medication will not exceed 16 mg for any patient.

2) Please note that this clinic has taken the position that buprenorphine-naloxone (Suboxone) is an appropriate medication for most pregnant women. Patients who are prescribed buprenorphine-only preparations (Subutex) during pregnancy will be immediately transitioned to buprenorphine-naloxone preparations following delivery.

3) Patients must pick a "home pharmacy" and sign a release of information for that pharmacy.

D-8. IDN Community Project: Member Roles and Responsibilities *(No change January – June, 2019)*

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.

While the team has begun looking at sustainability of efforts, the team continues to fully support the implementation and improvement of the intensive outpatient program. In the past contracting year, leadership decided to add additional support of a data analysis and research assistant to better collect and interpret data for purposes of improvement, evaluation and sustainability.

Project Team Member	Roles and Responsibilities
1.25 FTE Masters Level Clinician	5 part-time LICSW positions in total, 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 *Note: .2FTE currently open*
0.1 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 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 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 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)
0.4 FTE 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.
0.3 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 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.
0.3 FTE Research Assistant	Provides support to the team in data collection, evaluation and presentation
0.1 FTE Data Analysist	Provides support for data extraction and analysis for program evaluation

D-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3 (*Updates July – December, 2019)*

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-IOP 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. Trainings completed by staff this reporting period include:

- Circle of Security
- Moral Recognition Therapy
- Dialectical Behavioral Therapy

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. In the past reporting period the team made updates to the curriculum (below);

Moms in Recovery IOP Curriculum

IOP meets three days per week, for three hours per day. Patient check in occurs at the beginning of each group

Day 1

First Half: Healthy Relationships and Self-Esteem

The following topics will be explored. Selection of topics is based on needs of group participants. Topics include:

- Self Esteem
- Communication
- Anger
- Self-Compassion/Self-Validation
- Healthy Relationships
- Guilt and Shame
- Vulnerability
- Boundaries
- Addiction as a Disease
- Unguarded

Materials:

Connections Curriculum by Brene Brown

Duluth Model Domestic Abuse Intervention Program handouts

DBT Skills Training Handouts by Marsha Linehan

Second Half: Enhancing Commitment Work

- Journal writing
- Developing and revising Plan of Self Care
- Developing and revising Recovery Action Plan
- Developing and revising Relapse Prevention Plan
- Developing and revising SMART Goals
- Completing Safe Coping Sheet

Day Two

First Half: Motivational Enhancement

The following topics will be explored. Selection of topics is based on needs of group participants. Topics include

- Progression of Disease
- Values
- Stages of Change
- Locus of Control
- Decisional Balance
- Change Plan/Looking Forward
- 4 Dimensions of Recovery/4 Paths to Long Term Abstinence
- Trust
- Spirituality
- Distress Tolerance

Second Half: Health Education Meeting

Includes

- Nutrition
- Sexuality
- Reproductive Health
- Dental Health
- Smoking Cessation
- Stress reduction
- Parenting issues
- Safe sleep and coping with crying
- NAS
- Labor and delivery

Day Three

First Half: Mindfulness Experiential Session

Includes

- Meditation Practice
- Mindfulness-based Movement Practice
- Mindfulness-based Activities Practice
- Relaxation Exercises
- Journal Writing
- Trauma Informed Yoga

Second Half: Relapse Prevention and Emotion Regulation

The following topics will be explored. Selection of topics is based on needs of group participants. Topics include:

- Changing Thoughts; Introduction to Cognitive Behavioral Therapy
- Seemingly Irrelevant Decisions and Self-Sabotage
- Post-Acute Withdrawal Syndrome
- Co-Dependency
- Denial and Honesty
- House of Sobriety
- Triggers and Cravings
- Warning Signs and High Risk Situations
- Rock Bottom
- Safety Planning
- Wise Mind/Addict Mind
- Stress
- Boredom

Materials:

DBT Skills Training Handouts by Marsha Linehan

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	6/30/19	12/31/19
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						

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

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

E5 Project Background

Region 1 IDN E5 work is spread across three types of projects which are outlined in the different reporting sections below. The Sullivan County Complex Care Team (SCCCT) is the main E5 project which has been in process since 2018. This project brings together multiple community based stakeholder which present de identified complex care cases for the team to discuss and provide insight in next steps for the presented case. The second E5 project is an extension of the SCCCT known as the Sullivan County Community HUB. This project looks to improve closed loop referrals for complex cases across the different community members that a patient/client may need to accommodate whole patient/client care. This is done through the completion of pathways which is a process of steps taken to resolve a need for social determinants of health and/or a behavioral health need. Finally, the third E5 project is in association with the Co-Pilot project described and reported on more in detail in the C1 SAR section. The Co-Pilot project is a melding of the C1 and E5 projects. The details for this third project are primarily covered in the C1 section where as the other two have more details in the following reporting sections.

Updates as of July – December, 2019:

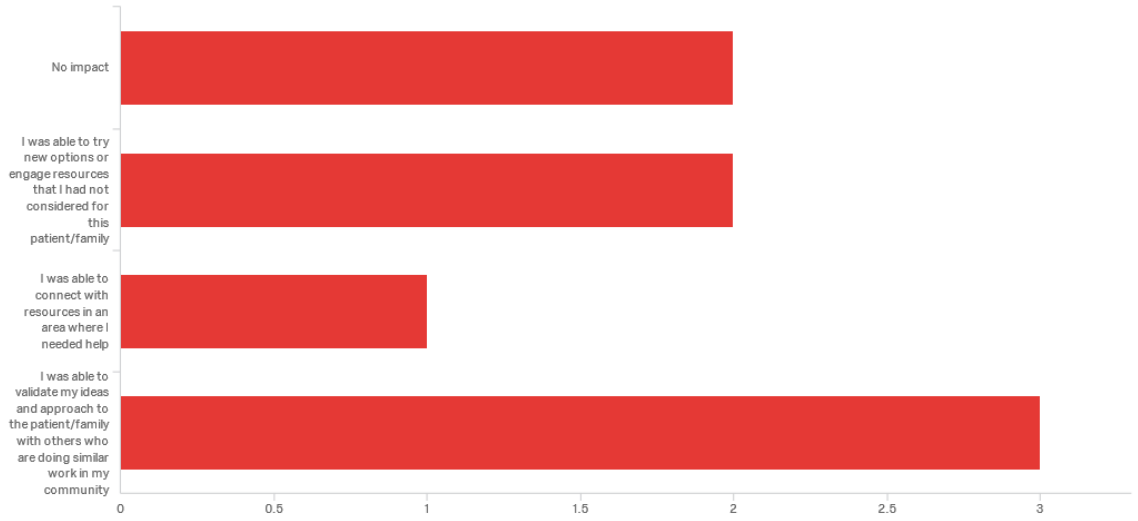
Sullivan County Complex Care Team Meetings

During the reporting period, the Sullivan County Complex Care Team (SCCCT) continued to hold successful monthly de-identified case review meetings. Each meeting saw on average two to four cases reviewed. While the case presentation themselves were beneficial for supporting organizations in possible follow-up for their clients as well as increase referrals and networking between agencies, there were several secondary benefits observed by the IDN administrative staff. These included networking, improved understanding of services offered at participating organizations, and improved partnerships between agencies. To further foster the community partner learning, the IDN program manager integrated into the monthly Knowledge Exchanges presentation by the organizations to allow for a deeper dive into service offerings. Additionally, during the month of November the SCCCT held a virtual meeting due to the case load volume. This meeting saw presentations from partners in Grafton County, allowing for an interesting learning experience. While clients/patients often travel for services between the two agencies the networking between the two counties on services seemed to offer room for improvement. As a result, the IDN administration hope to expand the County Complex Care Team meeting into Grafton County in the coming year.

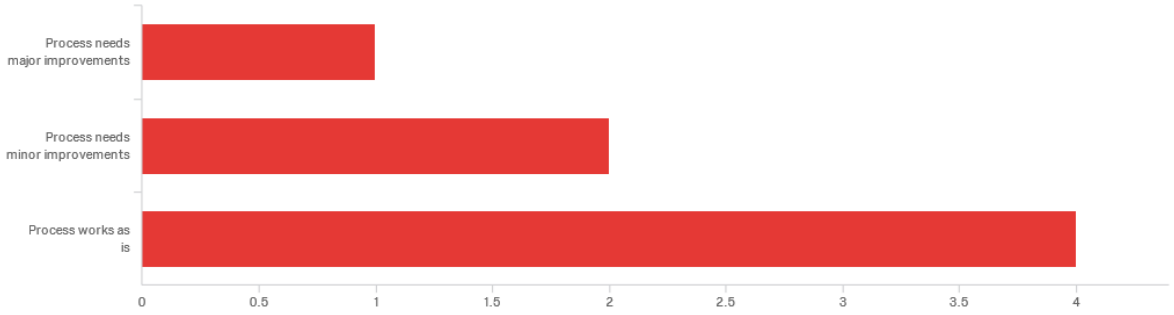
As the team grew more comfortable in case presentations opportunities for improvement began to present themselves in improving the facilitation of the meeting. While a high level agenda was presented a few days prior to the meetings, it was determined a day of agenda would be helpful. This would reinforce the information of the organizations presenting, support better flow between

presentations and better capture of follow-up action items. Additionally, it was determined it would be helpful to include the ground rules on the agenda. One consistent challenge is ensuring thoughtful communication between agencies. Often there are several agencies in the room which could offer a single needed service, this can often lead to intense confrontation and lead to speaking over one another. This is one area of improvement which the IDN administration will focus on in the upcoming year. Additionally, the IDN program manager distributed an evaluation survey in December of 2019 to receive feedback on more opportunities for improve. Results from the evaluation can be found below. These will be addressed in the New Year.

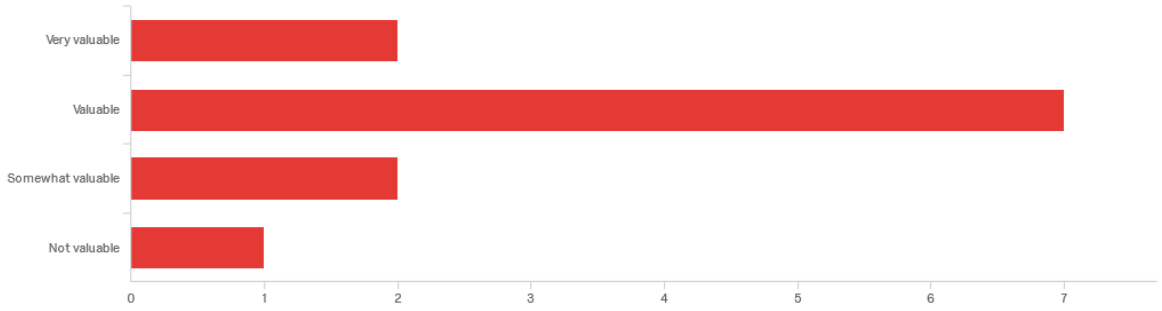
Q6 - How do you think the de-identified case discussion impacted your work? (Select all that apply)



Q7 - How would you rate the process for case presentations? (submitting, presenting, follow-up)



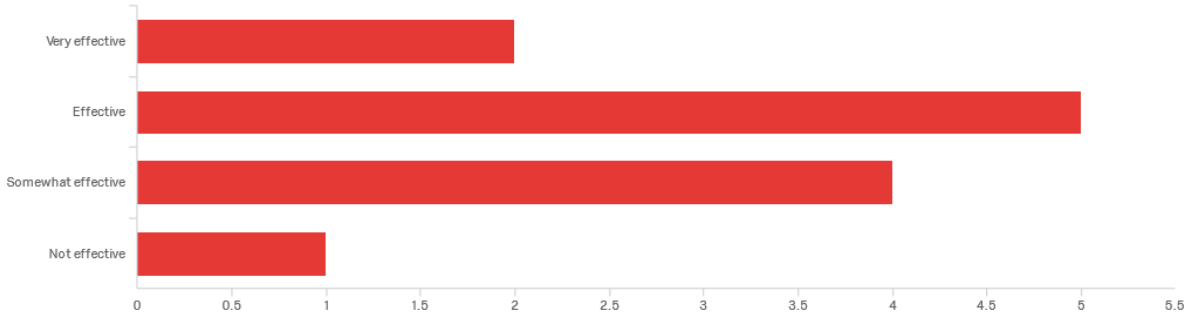
Q13 - How valuable has listening and supporting the presentation of de-identified cases by your peers been?



Q14 - Please explain what has been valuable, and/or how it could be more valuable.

Please explain what has been valuable, and/or how it could be more valuable...
It has allowed me to connect with my colleagues in the community and to "think outside the box".
It's great to see the collaboration taking place across community partners.
Allows everyone involved to get an even better idea of the strengths and services of each organization. Builds stronger partner relationships and improved continuity/wrap-around care for the clients.
Listing to the resources and creative solutions to complex problems that the team came up with helped me think about how to help address the complex needs of clients at our own agency. I was able to bring resources back to my agency.
It is nice to hear about resources or assistance that other partners offer that we may not have known about because it isn't as popular. It is also nice to debrief and bounce ideas off of other professionals to make sure we are doing everything we can to help our clients.

Q15 - How would you rate the effectiveness of the meetings?



Expansion of work utilizing the Pathways Community Hub Model in Sullivan County Hub Pilot:

In late summer of 2019, it was decided by the IDN 1 administration to expand the work of the Complex Care Team utilizing key members of the team to set up a Pathways Community Hub Model. This model is evidenced based and sets up a structure to allow those participating in completing pathways to receive payment based on their outcomes. In early fall the team began conversations with pilot organizations both asking for their participation and informing them on the model. In November, IDN 1 co-hosted a half day learning session with the Hub's creator for our partners. Additionally, a business/project plan of the expansion supported by the IDN 1 executive committee. From there a pilot team was created and the position of a Community Hub Manager/ Care Team Coordinator was hired as part of the IDN team. The pilot team participants included: Valley Regional Hospital, Newport Health Center, West Central Behavioral Health, South Western Community Services, Service Link and Sullivan County Department of Corrections. This pilot team will be split into a steering committee which supports the leadership and high level development of the work such as polices, payment structure and more as well as a project team which will focus on the on the ground operations. The teams currently meet bi-weekly in preparation for a quick planning phase and early implementation in the New Year. Below is the project charter and high level work plan.

region1

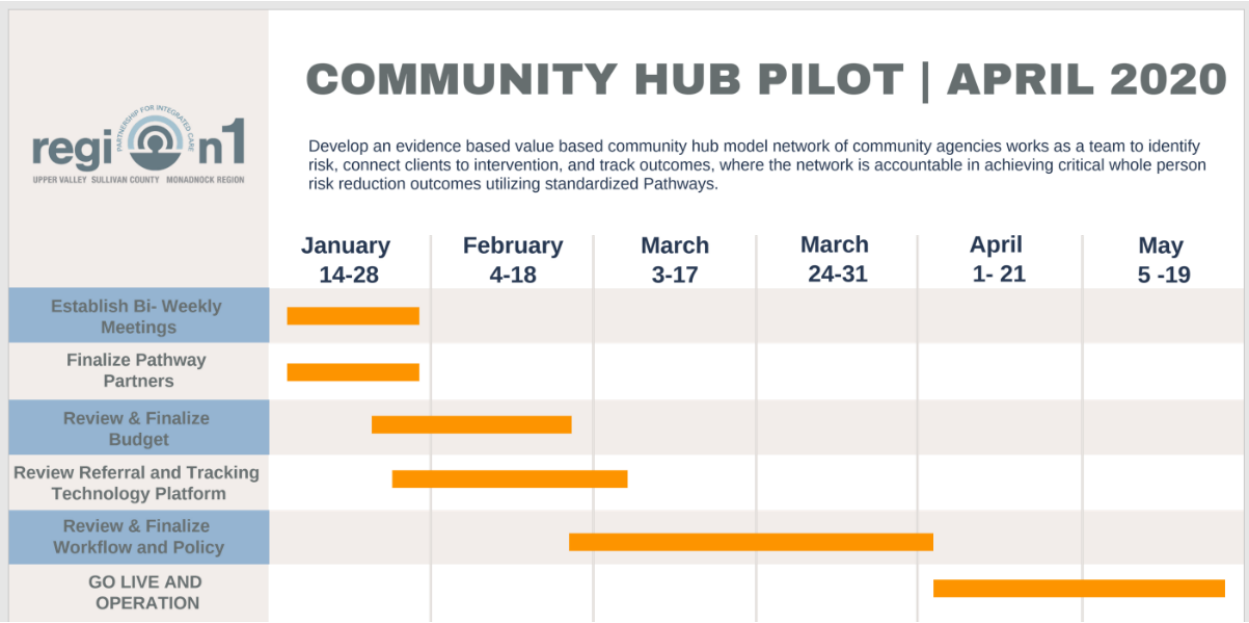
Sullivan County Community Hub Pilot Steering Committee Charter

Problem Statement
To utilize the existing Sullivan County Complex Care Team (SCCT) to develop an evidence based value based community hub model. This network of community agencies work as a team to identify risk, connect clients to intervention, and track outcomes, where the network is accountable in achieving critical whole person risk reduction outcomes utilizing standardized Pathways.

Business Case
This project aims to develop comprehensive care coordination/management services for high need adult and child populations with multiple physical health and behavioral health chronic conditions. These services are intended to maintain or improve an individual's functional status, increase the individual's capacity to self-manage their condition, eliminate unnecessary clinical testing, address the social determinants creating barriers to health improvement, and reduce the need for acute care services.

Objective	Related Criteria
Identify Project Team Members that include care coordinators/managers, primary care providers, and behavioral health providers from identified pathways	Utilize Environmental Scan for Pathways conducted in Spring, 2019 Coordinate with Steering Committee to determine Project Team Members
Develop and/or utilize protocols,policies, and strategies to identify and intervene with target population	Review evidence based model, Pathways Community Hub and existing protocols already in place with SCCT
Determine 3-5 attainable and realistic pathways for the pilot model	Review SCCT Trends for 2019 presented cases Review data reported from primary care SDoH data
Utilize technology based systems to track and share care plans such as, Unite Us or CMT	Coordinate with Statewide HIT Taskforce and Region 1 IT/Data Workgroup

Resource Plan	
Project Lead(s):	Community Hub Manager
Project Sponsor(s):	Region 1 IDN
Team Members	
Catherine Bardier	Leslie Hutchins
John Manning	Beth Daniels
Dr. Juliann Barrett	Donna Magee
Jen Seher	Bryan L'Heureux
Maryann Ferguson	Cynthia Twombly
Peter Mason	Mark Belanger
Stephanie Cameron	Jessica Leandri
Ashley Greenfield	
Milestones	
Community Hub Go Live	April 1, 2020
PCHI Certification	December 31, 2020



E5 Work as Part of Co-Pilot Project (see C1 SAR section for more detail) Update:

E5 team as part of the Co-Pilot project is conducted by Monadnock Family Services. In the summer of 2019, the project was challenges with smooth transitions between the two teams, so it was decided that each of the project participating organizations would be responsible for a level of care coordination, and they would continue to communicate regularly on a monthly bases. The team underwent one staff transition during the reporting period, but was able to quickly rehire having little impact on client volume.

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.*

The Target Table below is reflective of the Sullivan County Complex Care Team (SCCCT) project as it is the original E5 project for Region 1 IDN. Targets for the Community Hub are in development as the steering committee was formed at the end of December 2019 and will be meeting regularly starting January 2019. This Committee will be responsible for developing the targets for the Community Hub expansion project. The targets for the E5 project as part of the Co-pilot can be found in the C1 SAR reporting section.

Performance Measure Name	Target	Progress Toward Target				
		As of 12/31/17	As of 6/30/18	As of 12/31/18	As of 6/30/19	1/1/19 -12/31/19
Number of Cases Reviewed by the SCCCT	24 Cases (Annual)	N/A	N/A	6	11 since January,2019 additional reoccurring *Two meeting times used for privacy and consent or	26 Cases

					would be on track to hit target.	
SCCCT Referrals Made and Closed	100%	N/A	N/A	Not tracking	Process for tracking being created	100%
Expansion of SCCCT Membership	40 Organization	N/A	N/A	Addition of the following; Newport Health Center, NLH Representation, VRH representation, Valley Primary Care	Addition of the following: APD, DHMC Outpatient CHW representatives from all area medical agencies	Over 40 area agencies depending on availability to meet, see participating list below

SCCCT Reporting Template 2019-Current – This template is how referrals are captured of cases presented during the monthly meetings. The process for this is outlined in the protocol section of the reporting:

SCCCT referrals are suggested to the presenting agency as guidance to best support complex individuals and family cases. Referrals are acted upon by the referring agency following the SCCT. Outcomes are reported in the below format and shared with the SCCCT.

IDN Sullivan County Complex Care Team Meeting Case Presentation Referral Follow-Up

* Required

1. Please Tell us Your Agency *

2. Date of Original Case Presentation

Example: January 7, 2019

3. Case Identification # *

4. Were there referrals made based on the case presentation? *

Mark only one oval.

- Yes
- No
- Other: _____

5. How many referrals were made?

6. What organizations were the referrals made to?

7. How many of the referrals were followed-up on?

8. What organizations were the follow-ups made with?

This content is neither created nor endorsed by Google.

Google Forms

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.

Update July - December, 2019

During the reporting period, the IDN 1 administrative team hired a full time position which serves as both the Community Hub Manager and the Facilitator/Project Manager for the Sullivan County Complex Care Team (SCCCT). The IDN 1 Program Manager, while still serving in a supportive role, has transitioned the project responsibilities to the new position to ensure the continued improvement and sustainability of the SCCT in the final year. The SCCCT will also continue to receive support from the IDNs Medical Director. The E5 team of the Co-Pilot Project continues to be fully staffed a 2 FTEs serving a full client panel.

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	Staffing on 6/30/19	Staffing on 12/31/19
SCCCT Facilitator	.5 FTE	N/A	N/A	Consultant Hired for Contract Hours up to 5 hrs. per Month	Consultant Hired and In place for 5hrs Support Monthly	0 FTE	**1 FTE**
Enhanced Care Coordinators	2 FTE	0	2 FTE	2 FTE	2 FTE	2 FTE	**2 FTE**
Supervisor	.1 FTE	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	0.1 FTE, Current Staff: Re-allocated	**0.1 FTE, Current Staff: Re-allocated**

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.

With the loss of the facilitator position, there are currently no expenditures for the reporting period. With the expansion of the Pathways Community Hub Model, a new project budget was created. Expenditures will not be accurately captured until the next reporting period. IDN 1 administration had withdrawn QI support before the reporting period, so no cost was accrued during the reporting period. Below is the projected project budget.

2020 Operational Budget
Sullivan County HUB

Item	Cost	Total
Sullivan County Community Hub Manager- 1 FTE	[redacted]	[redacted]
Consulting Support for Design and Setup from PCHMI	[redacted]	[redacted]
(Optional) Certification by PCHI	[redacted]	[redacted]
Supervision	[redacted]	[redacted]
Technology licenses	[redacted]	[redacted]
Payment to HUB Partners (Referrals)	[redacted]	[redacted]

Total	$148,700

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 December 31, 2019:

Enhanced Care Coordination	- Total:	$186,554
Valley Regional		*$3,530*
Monadnock Family Services		*$183,024.1*

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 2017 Actuals	CY 2018 January to June Actual	CY 2018 July to Dec Actual	CY 2019 January to June Actual	CY 2019 July to Dec Actual	CY 2020 Projected
Total Salary/Wages	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Employee Benefits	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Supplies (Technology etc.)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Recurring Expenses	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Staff Education and Training	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Subcontracts/Agreements(see one time expenses)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
One Time Expenses	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total:	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Off-setting Revenue	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total Expenses - Revenue	$ 83,823.03	$ 107,661.00	$ 74,196.51	$ 84,484.80	$ 81,471.52	$ 193,323.00

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. It is the ultimate goal to re-seat project ownership within a Sullivan County.

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
Headrest	N/A
Kearsarge School District	N/A
Lake Sunapee VNA and Hospice	N/A
New London Hospital/Newport Health Center	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

With the unique breadth of the participating organizations and the services they provide, it was determined that one assessment across organizations would not suffice. Each organizations, as it is applicable to their model and function, uses an evidence based assessment tool unique to their services, the organizations utilize information collected from these assessment tools in conjunction with an agreed upon criteria for de-identified case presentations. This allows for a standardized approach to case presentation while preserving the variety of services and prevention of operational interruption in the organizations by adding an additional tool. Below is a table which illustrates some of the evidence based tools from our most frequent case presentation partners. It is not required the organization vet their evidence based tool with the IDN administration.

Example assessment tools used by participating organizations:

Community Based Organization	Standardized Assessment Tool
Newport Health Center	Comprehensive Core Standardized Assessment – where several participating organizations are B1 partners, many of them have been actively deploying the CCSA.
ServiceLink	National Outcomes Measurement System
TLC Family Resource Center	Family Caregiver Assessment Tool
Southwestern Community Services	Vulnerability Index-Service Prioritization Decision Assistance Tool
Southwestern Community Services	Child and Adolescent Needs and Strengths

Southwestern Community Services	Consolidated Health Economic Evaluation Reporting Standards
Valley Regional Healthcare	Comprehensive Core Standardized Assessment – where several participating organizations are B1 partners, many of them have been actively deploying the CCSA.

Criteria

- Case has more complex needs related to medical, behavioral health and/or social determinants of health
- Case has need which is serviced outside of presenting organization
- Case supporting organization has exhausted all options in helping clients

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 December, 2019:

Where it is applicable to have collective referral processes and protocols for group management the IDN team has facilitated initiatives to support the development of these tools. Given the nature of the coalition type work undertaken by the Sullivan County Community Care Team and the newly formed Sullivan County HUB it is not clinically appropriate for a standardized assessment or treatment plan. See the C1 section of the report for additional details on some of the tools used by the Co-Pilot team (C1/E5 hybrid project)

Sullivan County Complex Care Team (SCCCT) Meeting Protocol

During the reporting period, a draft protocol was developed for the Sullivan County Complex Care Team (SCCCT) meetings and the de-identified case presentations. Below is the implemented protocol which will continue to be living document in draft format as the SCCCT further improves their efforts.

Integrated Delivery Network Region 1 (IDN1)

Sullivan County E5- Complex Care Team

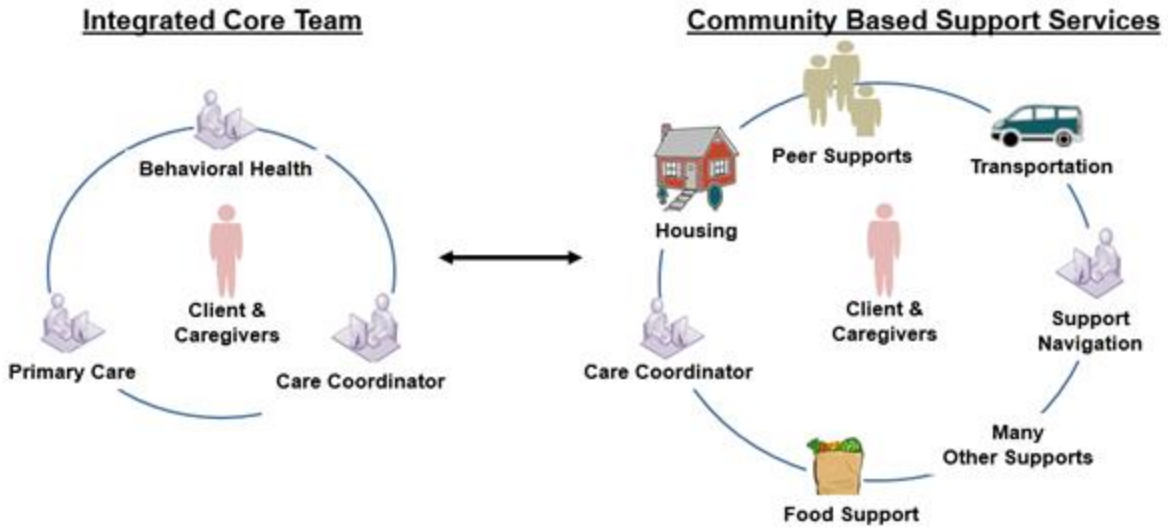
Protocol

V1.0 October 2019

The purpose of this document is to guide IDN-1 Partners in the E5 Complex Care Team process. 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 Region 1 IDN at info@region1idn.org.

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 E5 Project, known as the Sullivan County Complex Care Team (SCCCT), convenes community partners to identify and eliminate duplicative services and improve health outcomes across Greater Sullivan County.



The following Protocol will define the following:

- The SCCCT Membership
- How Referrals are made to SCCCT
- Response to Referrals made during SCCCT

SCCCT Membership

The Sullivan County Complex Care Team (SCCCT) is comprised of community partners from several organizations that serve the community, including those with complex needs. There are currently no prohibitions of community partner organizations from joining or engaging in the SCCCT. The SCCCT firmly believes that the more partners, the better the outcome for the complex cases that are shared.

Current Membership for the SCCT includes:

Baby Steps
Children of Incarcerated Parents
City of Claremont
Claremont Chamber of Commerce
Claremont Connect Center
Claremont Soup Kitchen
Colby-Sawyer College
Counseling Associates
DCYF
Department of Corrections, Sullivan County
DHHS
Episcopal Curate of Sunapee St. Andrew's, New London, NH, Epiphany, Newport, NH

Fall Mountain School District
Greater Sullivan County PHN
Green Mountain Children's Center
Groups
Headrest
Kearsarge School District
Lake Sunapee VNA and Hospice
New London Hospital/Newport Health Center
NH Employment Services
NH JAG
One for All SAU 6, Claremont
Pathways
Planned Parenthood
Regional Access Points
River Valley Community College
SAU 43- Newport
SAU 6- Claremont
Second Growth
ServiceLink
Shining Success
South Congregational Church, Newport
Southern NH Services
Southwestern Community Services
Sullivan County United Way
Sunapee School District
TLC
Tri-County Community Action
Turning Points Network
UNH Cooperative Extension
Valley Regional Hospital
Vital Communities
West Central Behavioral Health
Valley Regional Hospital
GROUPS Recover Together
Southwestern Community Service
SAU-6 FAST Forward 2020

New members may join any time and engage in the monthly complex care team meetings. Meetings occur on the 1st Wednesday of each month from 11:00AM- 12:00PM and alternate between Claremont and Newport, New Hampshire.

Referrals to the SCCCT

Complex care cases are presented at the SCCCT monthly meetings. Cases are requested at the end of the meeting prior. If no cases are identified in the meeting prior, a request for cases is sent out to membership at least three weeks before the next meeting.
Referrals to the SCCCT stem from organization specific evidence based assessment tools (examples below). Once assessed presenting organizations utilized the below criteria for case selection.

Assessment tools used by organizations

- Comprehensive Core Standardized Assessment – where several participating organizations are B1 partners, many of them have been actively deploying the CCSA.
- National Outcomes Measurement System
- Family Caregiver Assessment Tool
- Vulnerability Index-Service Prioritization Decision Assistance Tool
- Child and Adolescent Needs and Strengths
- Consolidated Health Economic Evaluation Reporting Standards

Criteria

- Case has more complex needs related to medical, behavioral health and/or social determinants of health
- Case has need which is serviced outside of presenting organization
- Case supporting organization has exhausted all options in helping clients

When a case is received, the SCCCT facilitator shares the de-identified case with the membership at least one week prior to meeting to provide community partners to process and provide feedback to the referring agency. Flow for the referral process below.

SCCCT Form Template

Community Care Team (CCT) Case Consultation Form

Date:	
Agency POC:	
Case #	

Primary Case Consultation Question/Concern:

What are the primary concerns you are bringing to the Case Consultation Team (CCT)? What are the family's goals? What are the most pressing issues? How can the CCT assist?

-
-
-
-

Demographic Information:

Household Members:	Age	Gender	Ethnicity/Race	Employment	Education	Marital Status	Primary Language	Military Service?	Does this person have a Proxy?

Identified Strengths:

What strengths has the client identified? What strengths do you identify?

-
-
-

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- See Eco Map Option Below		

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Income/Expense Sheet

Monthly Income	Monthly Expenses

Presenting Concerns (Check all that apply): What are the primary areas of concern?

"X"	Domain	Notes:
	Housing	
	Finances	
	Food/Meals	
	Transportation	
	Utilities /Bills	
	Education	
	Physical Health	
	Behavioral/Mental Health	
	Childcare	
	Employment	
	Social Isolation	
	Substance Use	

Eco-Map (Optional):

Referrals Suggested for this Family

Agency Referral To	Point of Contact	Date Due	Notes

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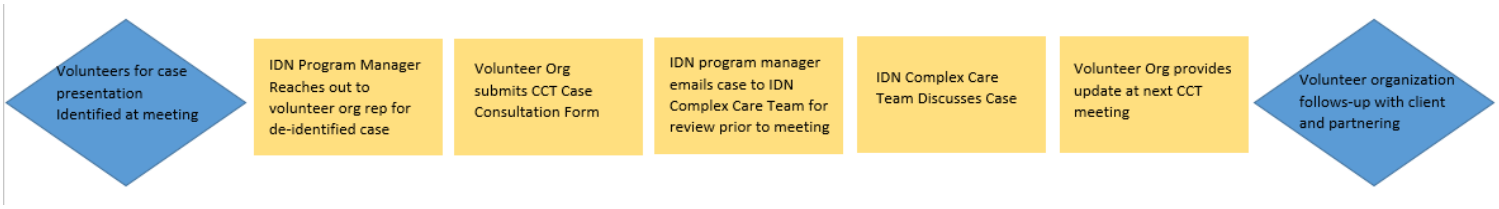
Referral Process Flow



Response to Referrals made during SCCCT

SCCCT referrals are suggested to the presenting agency as guidance to best support complex individuals and family cases. Referrals are acted upon by the referring agency following the SCCCT. Outcomes are reported in the below format and shared with the SCCCT.

In the event that a challenge arises with the referrals suggested during the SCCCT, the presenting agency is encouraged to bring the challenges back to the SCCCT to determine the next steps for the complex individual or family.

Referral Suggestion Template

Referrals Suggested for this Family

Agency Referral To	Point of Contact	Date Due	Notes

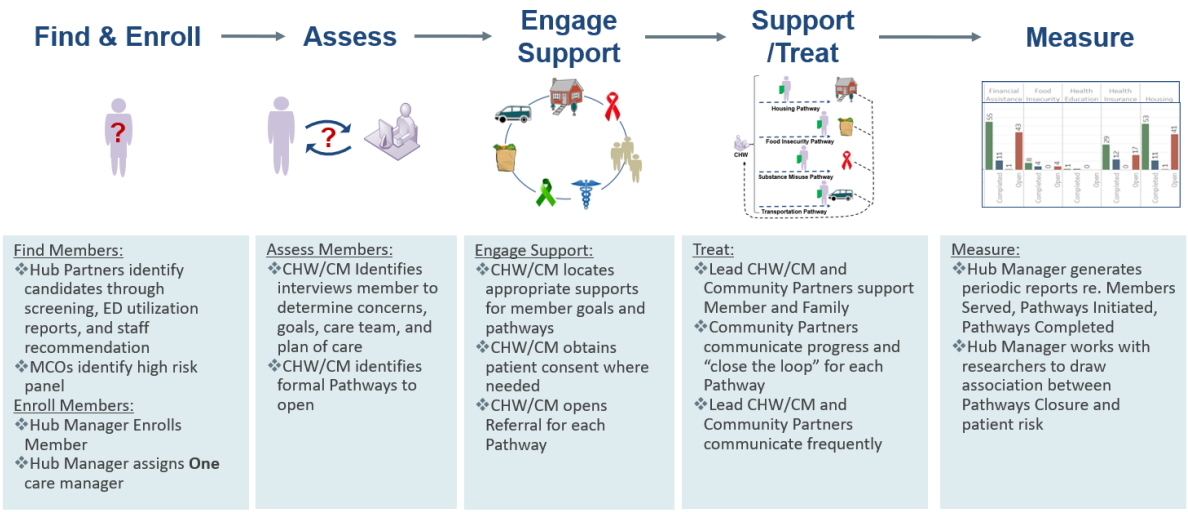
Protocol for Pathways Community Hub Pilot (living document to allow for continuous improvement during pilot)

The protocols for the Pathways Community Hub Expansion are pending implementation and may be updated pending feedback from participating organizations. Protocol is based off of evidence based guidance protocols.

Pathways Community Hub Sullivan County Pilot Protocols

Draft protocols to date (12/31/19) and are anticipated to be implemented for the launch of the Hub in spring 2020. These protocols follow the core functions of the Sullivan County Community Hub:

Figure 14: Sullivan County Community Hub - Core Functions



Protocols:

1. Find & Enroll: Identify appropriate Medicaid Members for services and Enroll Members [and Families] in the Sullivan County Community Hub.
2. Assess: Building from the screening and assessment that led to Member identification, meet with the Member to assess goals, concerns, and care team. Open formal care "Pathways" for each identified Goal / Concern.
3. Engage Support: Locate, identify, and connect with appropriate community agencies and organizations to support the Member and Family.
4. Support / Treat: Follow the evidence-based guidance for each open Pathway. Report progress and status to the Community Hub.
5. Measure: Generate periodic reports for key indicators of progress and challenges to be addressed.

Find and Enroll

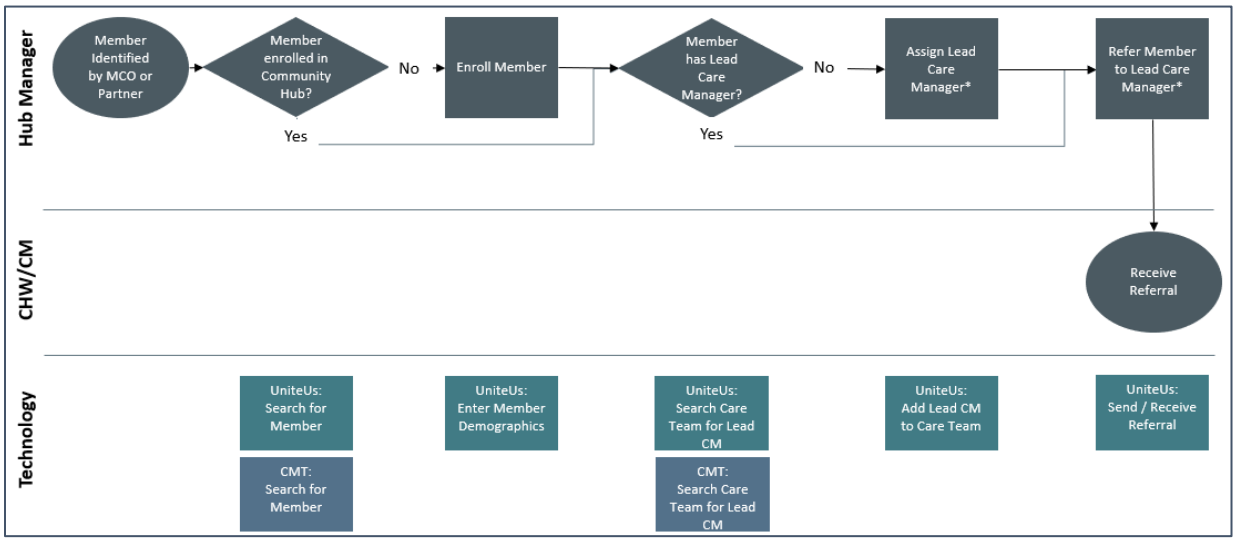
The Sullivan County Community Hub will draw upon two entry points for Medicaid Members, Managed Care Organizations (MCOs) and Community Partners. MCOs will identify high complexity high risk Medicaid Members through their risk stratification methodologies and will refer such Members to the Sullivan County Community Hub. Community Partners will identify high risk Medicaid Members through Comprehensive Core Standardized Assessment (CCSA) and/or Hospital Utilization reports from Collective Medical Technologies (CMT) for Community Partners engaged in B1: Integrated Care projects. (B1 protocols may be found in the B1 section of the SAR).

The following high-level workflow describes the "Find and Enroll" Process. Actors in this process are the Sullivan County Community Hub Manager and a Community Health Worker (CHW) or Care Manager (CM) of one or more of the Community Partner organizations. A technology "swim-lane" describes the use of IDN-1 Technology in support of the functions.

Key activities for this protocol are:

- **Find Members:**
    - **Hub Partners identify candidates through screening, ED utilization reports, and staff recommendation**
    - **MCOs identify high risk panel**
- **Enroll Members:**
    - **Hub Manager Enrolls Member**
    - **Hub Manager assigns One care manager [Note: Goal is to reduce duplication through single point of accountability]**

Figure 15: Find & Enroll Workflow



Assess

The Sullivan County Community Hub will draw upon CHWs and CMs from Community Partners to conduct assessments. All CHWs and CMs will be trained to assess Medicaid Members and to develop a Member Centric plan of care which includes health concerns, goals, and care team. Based upon the assessment, the CHW or CM will open appropriate standard evidence-based "Pathways" to define the next support and treatment steps. Assess Workflows and the Standard Pathways and their "near horizon" goals are listed below.

The following high-level workflow describes the "Assess" Process. Actors in this process are the Community Health Worker (CHW) or Care Manager (CM) of one or more of the Community Partner organizations. A technology "swim-lane" describes the use of IDN-1 Technology in support of the functions.

Key activities for this protocol are:

- **Assess Members:**
    - **CHW/CM Identifies interviews member to determine concerns, goals, care team, and plan of care**
    - **CHW/CM identifies formal Pathways to open**

Figure 16: Assess Member Workflow

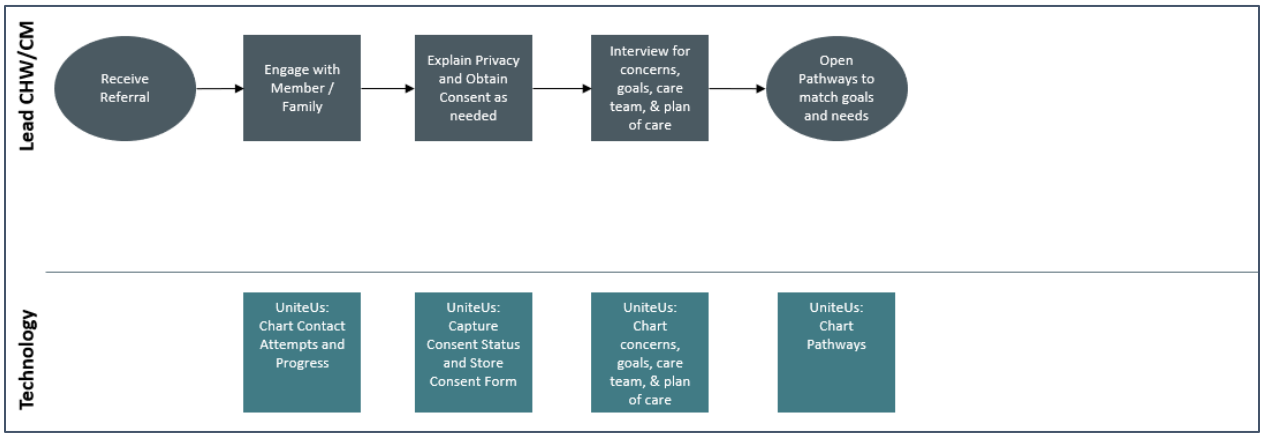


Figure 17: Social Determinant of Health Pathways

Pathway	What Does Success Look Like?
Baby/Family Support Services	Confirm at least 2 weeks prior to due date that client has met stated need: ❑ attended, signed up for, or declined parenting/childbirth classes or groups ❑ acquired needed supplies (diapers, clothing, car seat, breast pump) ❑ family engaged with DCYF; all CHW documentation Complete
Child Care	Client has had consistent access to child care for 1 month.
Education	Confirm that client successfully completes stated educational goal (e.g. Course/class completed, Training program completed, Quarter/Semester completed)
Employment	Client has been employed consistently over a period of 3 months.
Financial Assistance	Confirm client has had consistent access to financial resources for 3 months.
Food Insecurity	Follow up to confirm client has consistent access to healthy food for 1 month.
Housing	Confirm that client has moved into and remained in an affordable, suitable housing unit for a minimum of 3 months.
Interpersonal Safety	Follow up with behavioral health clinician and client in 1 month to confirm needs are being addressed.
Legal	Follow up in 3 months to confirm that legal needs are met, or that client is continuing to work with a resource/advocate to address ongoing issues
Transportation	Follow up to confirm client has maintained consistent transportation for 1 month
Other Client or Provider-Initiated Goal	Follow up with client and provider in 1 month to confirm the goal has been met or that plan is being consistently implemented and no further follow up is needed.

Figure 18: Medical and Behavioral Health Pathways

Pathway	What Does Success Look Like?
Health Insurance	Check weekly until client has received health insurance card.
Medical Home	Client has maintained relationship with primary care clinician for 3 months
Behavioral Health	Follow up with behavioral health clinician and client in 1 month to confirm needs are being addressed.
Dental	Follow up in 1 month to confirm client's dental needs have been met.
Health Education	Follow up in 1 month to confirm client has ❑ no additional questions regarding health education topic ❑ confirm any referrals have been completed (client successfully went to appointment) and needs have been met
Other Client or Provider-Initiated Goal	Follow up with client and provider in 1 month to confirm the goal has been met or that plan is being consistently implemented and no further follow up is needed.

Engage Support

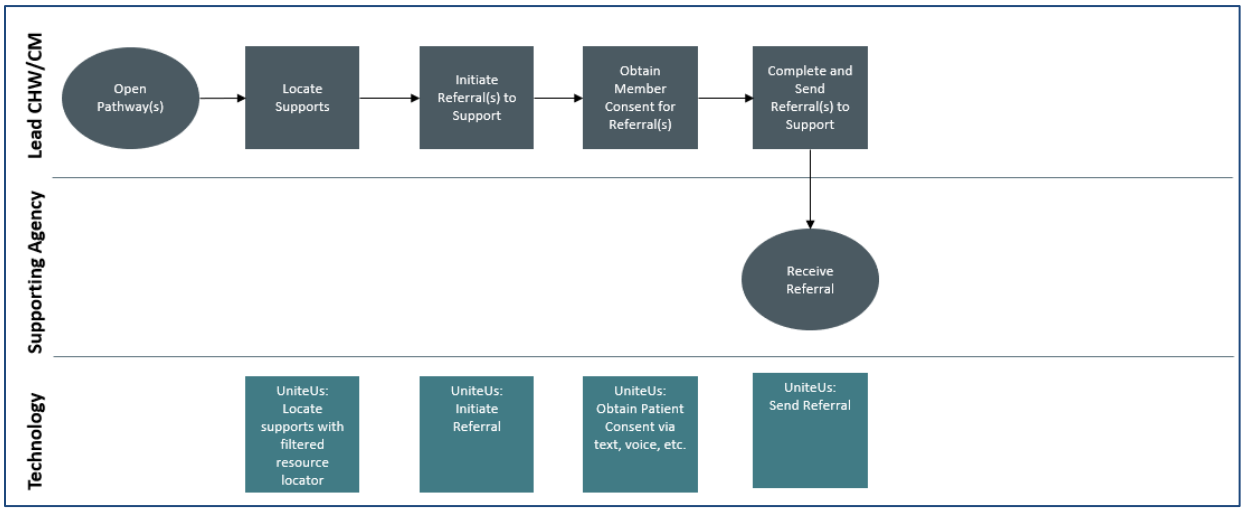
We recognize that it takes several organizations to support a Medicaid Member or Family with complex needs. The Sullivan County Community Hub will have a single lead CHW or CM and they will in turn identify, select, and connect with other organizations that can support. CHWs and CMs will be trained to identify supports that are most aligned with Member needs and constraints. CHWs and CMs will be supported with resource location and referral technology that will help them locate, connect, refer, and communicate with Community Partners.

The following high-level workflow describes the "Engage Support" Process. Actors in this process are the Lead CHW or CM and the Supporting CHW or CM. A technology "swim-lane" describes the use of IDN-1 Technology in support of the functions.

Key activities for this protocol are:

- Engage Support:
  - CHW/CM locates appropriate supports for member goals and pathways
  - CHW/CM obtains patient consent where needed (Note: The project will rely upon existing patient privacy guidance developed by IDN-1)
  - CHW/CM opens Referral for each Pathway

Figure 19: Engage Support Workflow



Treat Member/Family

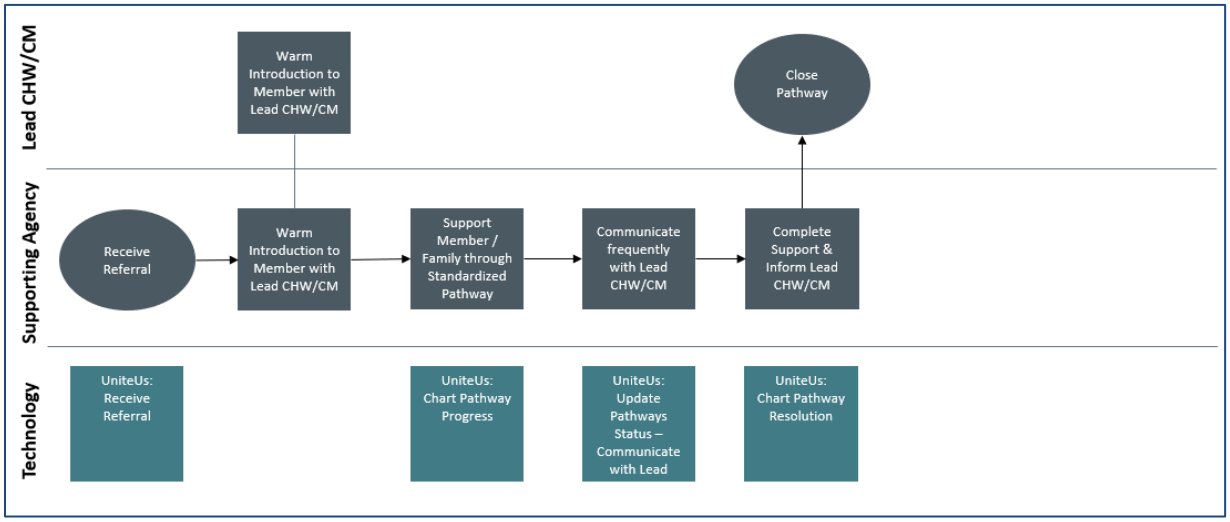
The Sullivan County Community Hub will draw upon CHWs and CMs from Community Partners to support and treat Medicaid Members and Families. All CHWs and CMs will be trained to shepherd a Member through one or more Care Pathways.

The following high-level workflow describes the "Treat" Process. Actors in this process are the Community Health Worker (CHW) or Care Manager (CM) of one or more of the Community Partner organizations. A technology "swim-lane" describes the use of IDN-1 Technology in support of the functions.

Key activities for this protocol are:

- Lead CHW/CM and Community Partners support Member and Family
- Community Partners communicate progress and "close the loop" for each Pathway
- Lead CHW/CM and Community Partners communicate frequently

Figure 20: Treat Member / Family Workflow



Report

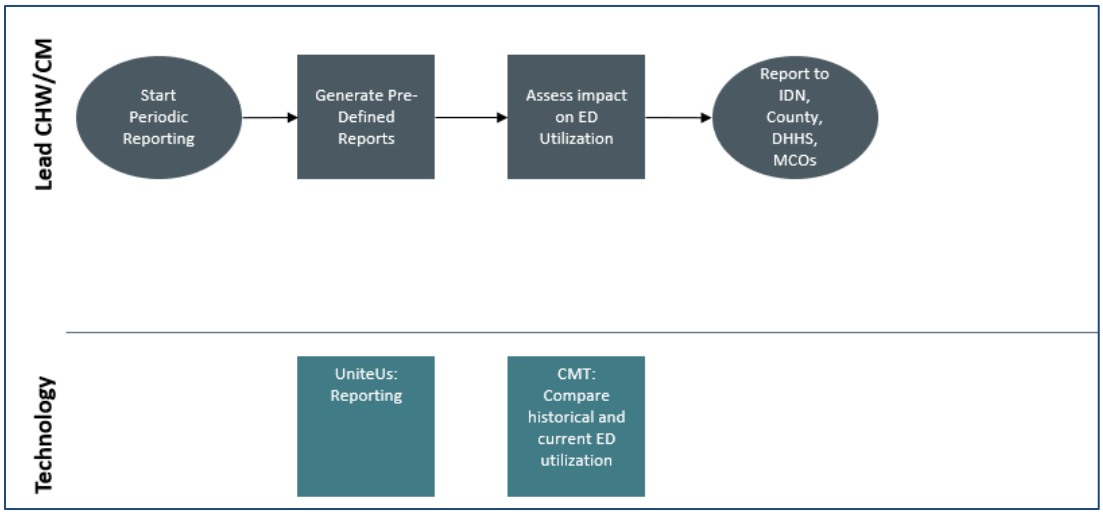
The Sullivan County Hub will develop and periodically generate multiple reports. There are two types of reports that are most important for the project: Operational Reports and Outcomes reports.

The following high-level workflow describes the "Report" Process. Actors in this process are the Sullivan County Community Hub Manager. A technology "swim-lane" describes the use of IDN-1 Technology in support of the functions.

Key activities for this protocol are:

- Hub Manager generates periodic reports re. Members Served, Pathways Initiated, Pathways Completed
- Hub Manager works with researchers to draw association between Pathways Closure and patient risk

Figure 21: Reporting Workflow



Initial Pre-Defined Reports are to include the following:

- # Members served in a given time period [Overall and by Hub Partner]
- # Pathways Initiated / Resolved in period [Overall and by Lead Partner]
- Difficult to fulfill Pathways (e.g., Housing)

The project will also look for ways to assess impact of the Pathways interventions. While we do not intend for this to be a research project the team will look at impact on ED utilization for those members that receive support.

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
Ashley Greenfield, SUD SMC	Community Hub Manager – SCCCT Facilitator Responsibilities: Project Management Support, Receipt of Case Referrals, SCCT Case Review Facilitation
Stephanie Cameron, IDN Program Director	Program Manager Responsibilities – Provide Community Hub manager for program support as needed

E-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3

During the July to December 2019 reporting period, focus was placed on the expansion of the Pathways Community Hub Model. Training was provided to the SCCT group at a SCCT meeting in August of 2019. Additionally, all partners at the SCCT table were invited to attend the half-day session by the model creator in November. As the model expands, there is identified training which will occur for participating organization in how to complete a pathways and interaction with the HUB.

Past trainings have focused on confidentiality which included a lunch and learn session from Lucy Hodder, JD in early 2019.

IDN 1 Administration often supports the fees associated with relevant trainings in the surrounding area. These opportunities are open to all SCCT partners to take advantage of. Additionally, as training are identified in the meetings as necessary, IDN 1 administration continues to support the gaps.

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	6/30/19	12/31/19
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 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. The medical providers in Region 1 have few APMs in place with the MCOs. Those that do, three sites, do so with NH Healthy Families.

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	Met
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures	Met	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	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	Met

DSRIP Outcome Measures for Years 4 and 5

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

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
		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	Status	December 2017 Notes	June 2018 Notes	December 2018 Notes	June 2019 Notes
Pre-Work						
	Continued Participation in Statewide BHWT	***Ongoing***	*Continued Statewide Collaboration in small groups and at the taskforce level*			*IDN1 Continues to attend all WT Meetings. Peter Mason, Medical Director and Jessica Powell, Executive Director cover all sub-committee meetings.*
	Deliverable: Submission of Statewide BHWT Strategic Plan	***Completed***				
	Deliverable: Signed Attestation of IDN Review and Acceptance of BHWT SP	***Completed***				
	Signed by Peter M. and Will T. as Region 1 Representatives	***Completed***				
Implementation Plan						
	Gap Analysis Development with C/WWG	***Completed***				
	Deliverable: Gap Analysis Narrative Submission	***Completed***				
	Timeline					
	Deliverable: Implementation Timeline	***Completed***				
	Phase 1 : Through December 2018 (Detailed)					
	Phase 2: End of Implementation Plan (High-Level)					
	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***				
	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***	***Completed***	*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.*	*Reached out to partners for existing job fairs and circulated information among our partners; follow up on the statewide workforce; Peter participates in the Primary Care Commissioner meetings; engaged with Bi-State, IDN 1 funded partners are paying for Bi-State consultation as well*	*IDN1 Continues to update and share Job Fair resources on behalf of network partners whenever possible.*
	"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*			

	Deliverable/Milestone	Status	December 2017 Notes	June 2018 Notes	December 2018 Notes	June 2019 Notes
	"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	**Completed & Ongoing**	*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.*	*IDN 1 decided not to post positions on our website due to the number of partners, integrity of updating, three sub-regions and potential cannibalization of partners; however, IDN 1 has executed two loan repayment strategies and communicated appropriately*	*IDN1 released additional loan repyament dollars through Workforce RFA in the Jan-Jun term*
	Include BiState Primary Care on all Regional Workforce Meetings	**Completed**				*Included on listserve and attend regularly*
	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	**Completed & Ongoing**	*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.*	*IDN 1 approved up to $160K to support the State Loan Repayment program*	*IDN1 continues to support the State Loan Repayment program as possible*
	Develop a supervision plan to meet the needs determined by the Supervision Committee convened in Fall, 2017	**Completed & Ongoing**	*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.*	*Workforce workgroup continues to talk about supervision and needs of its employees; IDN 1 issued phase II of workforce RFA allocating another round of funds for supervision*	*Workforce workgroup continues to talk about supervision and needs of its employees; IDN 1 issued phase III of workforce RFA allocating another round of funds for supervision*
	Scheduled Semi-Annual HR Directors Meetings in Region 1: Addressing ongoing challenges and success of Region 1 Workforce efforts	**Completed & 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 these meetings on a semi-annual basis.*	*Scheduled meeting with partner Human Resources representatives (or executive leadership as appropriate) in November & December to highlight specific needs in recruitment and retention; discussion helped to inform phase II of workforce RFA*	*Ongoing workforce input for phase III of workforce RFA*
	Assess Website - One Point Information for BH Positions Use at 6 Month Intervals	**Completed & Ongoing**		*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* *Feb: 4097*	*IDN 1 decided not to post positions on our website due to the number of partners, integrity of updating, three sub-regions and potential cannibalization of partners; however, IDN 1 has executed two loan repayment strategies and communicated appropriately*	*IDN1 shares information on behalf of network partners as requested but holds to the decision to not post positions*
	Joint "Trailing Partner" recruitment strategy finalized and shared with all adopting Region 1 Partners	**Completed & Ongoing**		*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.*	*Developed communication strategy/protocol to share with Region 1 Partners and other industry leaders across sub-region to develop partnership in recruiting the 'trailing partners' of behavioral health candidates (at all levels). Shared with Region 1 IDN at December workforce workgroup meeting. IDN 1 team is continuing to contact major employers as well as Chambers of Commerce's in each sub-region. IDN 1 had discussions with the Greater Monadnock and Claremont Chambers*	*Ongoing efforts are being made to align with trailing partner initiatives at employers in the IDN region.*

	Deliverable/Milestone	Status	December 2017 Notes	June 2018 Notes	December 2018 Notes	June 2019 Notes
	Implementation of Supervision Plan				*see above - ongoing - there isn't one supervision plan across our region*	*see above - ongoing - there isn't one supervision plan across our region*
	Operationalize Recruitment with Regional Employers					
	Applications Accepted for Loan Repayment	***Completed & Ongoing***		*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.*	*Released second phase of Workforce RFA with increased funding for loan repayment; continue to offer up to 16 $10K matches for state loan repayment*	*Released phase III of workforce RFA with funding for loan repayment; 13 awards at $10k*
	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 Partner List across all Projects (A2, B1, C1, D3, E5)					
	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***	***Completed & Ongoing***	*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.*	*Statewide celebration occurred at the NH Behavioral Health Summit in December. IDN 1 helped to plan and sponsor the IDN training track. We align the public health networks in our sub-regions; IDN is present; we leverage existing community forums; health equity; substance misuse*	
	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***	***Completed & Ongoing***	*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.*	*Statewide celebration occurred at the NH Behavioral Health Summit in December. IDN 1 helped to plan and sponsor the IDN training track. We align the public health networks in our sub-regions; IDN is present; we leverage existing community forums; health equity; substance misuse; also spoke at delegation and county commissioner meetings*	

Deliverable/Milestone	Status	December 2017 Notes	June 2018 Notes	December 2018 Notes	June 2019 Notes
Developed and operational financial support plan will be in place with committed IDN funds- linkages to all other community based project budgets - Completed not later than June 2018	**Completed**			*allocation of community support funds; targeted community support agencies for needed resources*	
Operational IDN partner staff salary support addressing entry-level positions supplemental funding	**Completed**		*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	**Completed & Ongoing**			*We receive quarterly reports and evaluations from our partners receiving workforce funds on impact and retention*	*We receive quarterly reports and evaluations from our partners receiving workforce funds on impact and retention*
Additional supported community forums, emphasizing mental health topics will be scheduled as requested				*see above - public health networks; substance misuse; county meetings with delegates and commissioners*	*see above - public health networks; substance misuse; county meetings with delegates and commissioners*
Education Activities and Milestones					
Identification of partnering regional educational institutions interested in developing new, and enhancing existing, behavioral health training programs	**Completed & Ongoing**	*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*	*Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC; t*	*Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC; t*
Region 1 IDN Meeting with NH AHEC: Strategy development about enhancing educating student health professionals in collaborative practice and team-based models of care	**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	**Completed**	*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 $35,000requested. 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.*	*partners have limited capacity due to financial and time constraints; no reimbursement; limited capacity of those qualified to supervise; etc. Region 1 issued a second RFA with additional funds to support internship stipends and organizations' ability to support interns.*	
Functional workgroup of participating student and trainee internship supported agencies - Meeting quarterly	**Completed & Ongoing**	*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*	*Region 1 IDN offered $75,000 towards Internship Stipends and Organization Capacity to Support Internships in its Phase I Workforce RFA and approved all $35,000requested. 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*	*Get updates at workforce meetings; ongoing discussion; part of HR discussion; and receive quarterly updates from IDN-funded organizations on internship programs*	*Get updates at workforce meetings; ongoing discussion; part of HR discussion; and receive quarterly updates from IDN-funded organizations on internship programs*
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	**Completed & Ongoing**		*Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC*	*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.	**Completed & Ongoing**		*Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC*	*Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC; have $25K to support it;*	
Creation of a comprehensive list of student and trainee sites developed and shared	**Completed & Ongoing**		*Interns have just been brought on this summer through IDN - funding. Additionally, this should be a statewide goal.*	*Nancy Frank - statewide education and training - Sandy Blunt*	
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	**Completed & Ongoing**			*Statewide Training & Education - Sandy Blunt*	
IDN supported additions to the student and trainee sites offered	**Completed & Ongoing**			*Statewide Training & Education - Sandy Blunt*	
Continued development and progress on the inter-professional collaborative practice curriculum developed	**Completed & Ongoing**			*See above*	

Deliverable/Milestone	Status	December 2017 Notes	June 2018 Notes	December 2018 Notes	June 2019 Notes
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	***Completed & Ongoing***	*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 entire region.*	*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 entire region. Ask Phil*	*IDN1 renewed funding to WCBH for an additional 6 MHFA trainings in Upper Valley and Sullivan County in 2019.*
Offer trainings for clinical staff on Universal SBIRT usage and Motivational Interviewing	***Completed & Ongoing***	*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 Initiative but we will encourage further training in the next year. Additionally, Region 1 has an Intro to MI training on July 25th and then a two part training scheduled for September 25th and October 2nd.*	*All of our partners have access to the CHI/JSI SBIRT MI Initiative but we will encourage further training in the next year. Additionally, Region 1 has an Intro to MI training on July 25th and then a two part training scheduled for September 25th and October 2nd.*	*IDN1 due to requests supported two more MI trainings in late spring, early summer 2019*
Schedule trainings for assessing MAT expansion capability across IDN partner primary care sites - Assess progress across providers	***Completed & Ongoing***	*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.*	*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.*	*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 providers	***Completed***				*Offered focused Knowledge Exchange session on 42 CFR updates*
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	***Completed & Ongoing***		*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.*	*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. Ask Phil*	
Begin implementation of new self-management programs -				*Move to delete this from Implementation Plan*	
Schedule Region-wide training sessions in cultural competency	***Completed & Ongoing***				
Schedule Region- wide training sessions in suicide prevention	***Completed***			*Headrest did a suicide prevention training; forwarded NH Healthy Families two module training to all partners several times*	
Progress and expansion of Region 1 IDN Primary Care capacity to offer MAT	***Completed & Ongoing***		*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	***Completed & Ongoing***		*All of our partners have access to the CHI/JSI SBIRT MI Initiative but we will encourage further training in the next year. Additionally, Region 1 has an Intro to MI training on July 25th and then a two part training scheduled for September 25th and October 2nd.*	*Region 1 IDN continues to offer MI trainings and disseminate previously recorded trainings.*	*Region 1 IDN continues to offer MI trainings and disseminate previously recorded trainings.*
Support dissemination of the "Know the Five Signs" program through changedirection.or	***Completed & Ongoing***				
All Region 1 B1 providers have completed the SBIRT and MI training	***Completed & Ongoing***			*All B1 providers have access to these trainings*	*All B1 providers have access to these trainings*
All Region 1 B1 Providers Billing, Administration staff trained in MH and SUD	***Completed & Ongoing***			*All B1 providers have access to these trainings*	*All B1 providers have access to these trainings*
All IDN partner staff have had access to suicide prevention and cultural competency	***Completed & Ongoing***				

Page 2

Appendix B1-2: DH-Heater Rd and WCBH

Deliverable/Milestone	Task Assignments		Ongoing
Implementation Year 1	**Lead**	**Support**	
Charter Completion- Final review and approval by all project team members	Molly O.	Jessica P.	
*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 at alternating site locations to support attendance across organizations	Molly O.	Jessica P.	
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	Jessica P.	Molly O.	
Support and document MDCT meetings monthly and case assessment process	Michelle L.	Tyler V.	
Recruit to Hire - M1, 2			
Document weekly progress toward position hiring and share with broader project team membership	Matt D.	Joanne W.	
Share job descriptions and links to postings with all project team members	Matt D.	Joanne W.	
Assign team member lead support for communication of progress and interview panel updates	Matt D.	Joanne W.	
Onboarding			
Formalize and document the onboarding and training process CTC	Matt D.	Joanne W.	
*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	All Pteam	Molly O. / Jessica P.	
*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	All Pteam	Jessica P.	

Training			
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	All Pteam		
Train MDCT in roles and responsibilities	All Pteam		
Train MDCT in use of SCP and secure messaging	Mark B.		
Train community partners in use of SCP and secure messaging	Mark B.	All Pteam	
Train patients and families in use of SCP- IDN Supported	IDN Supported	All Pteam	
Determine physical health, mental health and SUD topics for MDCT training	All Pteam	Molly O.	
Decide on standardized, evidence-based training materials	IDN Supported		
Develop training schedule, including update schedule	Jessica P.	Pteam	
Train all staff in cultural sensitivity and destigmatization	IDN Supported		
Offer annual training to all project team membership on chronic disease management in the following domains:	IDN Supported		
Diabetes Hyperglycemia	IDN Supported		
Dyslipidimia	IDN Supported		
Hypertension	IDN Supported		
Mental Health Topics (Mulitple)	IDN Supported		
SUD Topics (Multiple)	IDN Supported		
Offer basics of mental health first aid to practice billing and reception staff annually	IDN Supported		
* 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	Tyler V. / Joanne W.	Nancy N.	
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems and current relationship with WCBH	Nancy N.	Cynthia T.	
Create a list of the patients who are seen most frequently for behavioral/mental health problems	Tyler V.	Joanne W.	
Create a sub-list of patients with documented SUDs, including substance(s)	Tyler V.	Joanne W.	
Process Mapping and Patient Flows			
Complete intake and screening process at WCBH	Nancy N.	Cynthia T.	
Finalize patient flow at both onboarding patient sites - WCBH, DH	Tyler V./Nancy N.	Molly O.	
Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision points	Molly O.		
Process Milestones and Reporting			
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM	Molly O.	Jessica P.	
Finalize operational dashboard for measures and measure collection	Jessica P.	Mark B.	
Present to larger project team for approval and finalization	Jessica P.	Molly O.	
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	Jessica P.	Chelsea W.	

Continuously collect and interpret outcome data- **M3**	Data Lead Role		
Review pledged project outcomes with all partners	Data Lead Role		
Schedule quarterly project outcome review	Jessica P.		
Schedule quarterly report targets and deadlines	Jessica P.		
Analyze and review 6 months of project outcomes -**M4**	All Pteam		
Review and assess potential supplemental funding opportunities -**M4**	All Pteam		
*Focus on project sustainability			
Comprehensive Core Standardized Assessment			
Continue CCSA development and coordination with DH SDoH taskforce	Joanne W.	Chelsea W.	
Training across B1 teams on CCSA Implementation	All Pteam		
Crosswalk these domains with existing demographic, SDOH, and screening instruments currently in use	Molly O.	Jessica P.	
Integrate finalized CCSA into existing EMR	Mark B.	Jessica P.	
Integrate CCSA into workflow	All Pteam	Molly O.	
Address coordination with WCBH utilization of DLA20	Nancy N.	Molly O.	
Produce and finalize documentation with project team attesting to the tools in use across the project team and crosswalk to IDN determined domain areas	All Pteam	Molly O.	
Comprehensive Core Standardized Assessment (Pediatric)			
Determine the developmental screening instrument to be utilized with the CCSA			
Integrate developmental screening into existing EMR			
Integrate developmental screening into workflow			
Shared Care Plan			
Project team demo on SCP portal and needs	Mark B.	Jessica P.	
Address inclusion of non covered entities on SCP	Mark B.	Jessica P.	
* Look to Legal/Privacy for required consent, next steps and training			
Budget			
Establish use of funds tracking for pilot within current system - IDN	Jessica P.		
*Address unique DGR project code for salaries and expenditures			
Create funding matrix to show IDN funded areas and other supported positions, activities	Jessica P.		
Establish use of funds tracking and budget table	Jessica P.		
Share quarterly with IDN	All Pteam		

Key Organizational and Provider Participants			
Share formal award notice to all partners and supporting organizations	Joanne W.	Molly O.	
Document and continually support referral partnerships	Joanne W.	Molly O.	
Address any gap areas in partner support network- target through new partner cultivation	All Pteam	IDN	
Address cultural barriers and look to supported IDN trainings on culture change	All Pteam	IDN	
Network Development - M2, M3			
Project team review and identification of all formal project partners and community supports	All Pteam		
Assign team members to support development and outreach	Molly O.	Jessica P.	
Continue to expand and develop the network of collaborating organizations	All Pteam		
Review current process for developing new partner relationships	Molly O.	Jessica P.	
Privacy & Security			
Train Staff on Treatment of Sensitive Patient Information			
Execute Data Sharing Arrangement with Support Services Organizations **-M2**	Data Lead Role		
*Identify areas where updates or new development is needed			
Linkage to IDN resources and forms	Jessica P.		
HIT Implementation			
Deploy Shared Care Plan Application	Mark B.	IDN Supported	
Deploy Direct Secure Messaging Application	Mark B.	IDN Supported	
Deploy Event Notification Application	Mark B.	IDN Supported	
Deploy Clinical Quality Measurement Application	Mark B.	IDN Supported	
HIT Components Completed and Functional - **M2, M3**	Mark B.	IDN Supported	
Utilize the IDN suppported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup	Mark B.	IDN Supported	
Integration Assessment			
Complete SSA at 6, 12, 18 month intervals	Molly O.	Jessica P.	Ongoing
Projet team coordination for SSA completion, submission, and review	Molly O.	Jessica P.	
Evaluation			
Review for inclusion of evidence based practices determined in implementation plan	All Pteam		
At 6 month intervals (12/31/17, 6/30/18, 12/31/18) measure	Molly O.	Jessica P.	
# of external community support referals from B1 team	Molly O.	Jessica P.	
Progress towards coordinated care practice designation	Molly O.	Jessica P.	

Data Sharing			
Outcome data accumulated and reviewed	Jessica P.	Molly O.	
Approve and disseminate data sharing forms to all project partners	All Pteam	Molly O.	
Share SSA Integration levels with B1 provider cohort	Jessica P.	All Pteam	
*Support IDN efforts for data transparency through reporting and project outcomes presenentation			
Meetings and Reports			
Documented minimum requirement met quarterly	Reporting Lead	Jessica P.	
Knowledge Exchanges and IDN Involvement			
Share key learnings with IDN1 partners and participation quarterly	All Pteam	Jessica P.	
Use of Funds			
Appropriate use of project funds used monthly and actuals reported quarterly	Reporting Lead	Jessica P.	
Accountability of Time			
Accountability for use of staff time to serve project functions reported quarterly	Reporting Lead	Jessica P.	

Appendix B1-2: VRH and CA

2019 Launch of Pediatrics → Adults

QUARTER ONE			J	F	M	A	M	J	J	A	S	O	N	D
Administration	**Milestone #1**	**Evaluate first year compliance of CCSA and completion by patients**												
	Objective 1A:	Comply with IDN requirements by expanding CCSA to include *"How is your health?"* question.												
	Objective 1B:	Create pathway to address a positive answer to *"How is your health?"* CCSA question												
	Objective 1C:	Complete PDSA cycle on CCSA workflow and identify gaps; role of MSW												
	Objective 1D:	Role delination analysis and work with VPC (Stephanie)												
	Objective 1E:	Complete PDSA cycle on CCSA database and analysis of data												
	Objective 2F:	Review Special Consent for pending Pediatric roll out												
	Objective 1G:	Develop (1) 10-18 yr CCSA and utilize current developmental milestone assessents for <10												
	Objective 1H:	Build CCSAs into the EMR system												
	Objective 1I:	Create pathways to address revised CCSA's for each age group (1G)												
	Objective 1J:	Adjust workflow to include parent involvement												
	Objective 1K:	Introduce/train staff of VPC who are unfamiliar on goals/objectives & success to date												
	Objective 1L:	Introduce/train staff of AIM & Newport's VRPCP on goals/objectives & success to date												
	Objective 1M:	Introduce medical providers to program - May Medical Providers meeting												
	Objective 1N:	Adjust workflows for AIM and VRPCP; process mapping exercise												
	Objective 1O:	Introduce/train staff of Valley Family Physicians on goals/objectives & success to date												
	Objective 1P:	Adjust workflows for Valley Family Physicians; process mapping exercise												
Program	**Milestone #2**	**Expand Use of CCSA**	J	F	M	A	M	J	J	A	S	O	N	D
	Objective 2A:	***(scale back)*** CCSA given to **nonacute, annual visit** adult patients of Dr. Barrett												
	Objective 2B:	CCSA given to **nonacute, annual visit** adult patients of Julie Stewart, APRN												
	Objective 2C:	Expand pediatric CCSA to Dr. Barrett for **well child checks only**												
	Objective 2D:	Complete PDSA cycle for 2C												
	Objective 2E:	Expand pediatric CCSA to Dr. Sullivan for **well child checks only**												
	Objective 2F:	Expand CCSA to all **well child checks and adult annual visits** at VPC and VRPCP, Newport												
	Objective 2G:	Complete PDSA cycle for 2F												
	Objective 2H:	Expand pediatric CCSA to all **well child checks and adult checks** at Valley Family Physicians												
	Objective 2I:	Complete PDSA cycle for 2H												
	Objective 2J:	Combine CCSA PDSA cycles for a STAFFING IMPACT evaluation/analysis; identify gaps; expanded role of MSW and use of CHW												
	Objective 2K:	Continued Role delination analysis and work with MSW (Stephanie)												

Appendix B1-2: CMC/MFS

Deliverable/Milestone	Task Assignments		Q1	Q2	Q3	Q4	Ongoing	Status
Implementation Year 1	**Lead**	**Support**	**7/1/19 - 9/30/18**	**10/1/18-12/31/18**	**1/1/19-3/30/19**	**4/1/19-6/30/19**		
Charter Completion- Final review and approval by all project team members	Dee W.	Jessica P.						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 at alternating site locations to support attendance across organizations	Dee W.	Jessica P.						Complete
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	Dee W.	Jessica P.						Complete
Support and document MDCT meetings monthly and case assessment process	Project Team to Identify							Complete
Recruit to Hire - M1, 2								
Document weekly progress toward position hiring and share with broader project team membership	Project Team to Identify							Complete
Share job descriptions and links to postings with all project team members	Project Team to Identify							Complete
Assign team member lead support for communication of progress and interview panel updates	Project Team to Identify							Complete
Onboarding								
Formalize and document the onboarding and training process for NP	Project Team to Identify							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	All Pteam	Dee W. / Jessica P.						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	All Pteam	Jessica P.						Complete
Training								
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	All Pteam	Dee W. / Jessica P.						Complete
Train MDCT in roles and responsibilities	All Pteam	Dee W. / Jessica P.						Complete
Train MDCT in use of SCP and secure messaging		Mark B./Jaime D.						Complete
Train community partners in use of SCP and secure messaging		All Pteam						Complete

Deliverable/Milestone	Task Assignments		Q1	Q2	Q3	Q4	Ongoing	Status
Implementation Year 1	**Lead**	**Support**	**7/1/19 - 9/30/18**	**10/1/18-12/31/18**	**1/1/19-3/30/19**	**4/1/19-6/30/19**		
Train patients and families in use of SCP- IDN Supported	IDN Supported	All Pteam						Complete
Determine physical health, mental health and SUD topics for MDCT training	All Pteam	Dee W./Jan T.						Complete
Decide on standardized, evidence-based training materials	IDN Supported							Complete
Develop training schedule, including update schedule	Jessica P.	Pteam						Complete
Train all staff in cultural sensitivity and destigmatization	IDN Supported							Complete
Offer annual training to all project team membership on chronic disease management in the following domains:	IDN Supported							Complete
Diabetes Hyperglycemia	IDN Supported							Complete
Dyslipidimia	IDN Supported							Complete
Hypertension	IDN Supported							Complete
Mental Health Topics (Mulitple)	IDN Supported							Complete
SUD Topics (Multiple)	IDN Supported							Complete
Offer basics of mental health first aid to practice billing and reception staff annually	IDN Supported							Complete
* 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 Chesire Medical Center and Monadnock Family Services	All Pteam	Dee W. /Stephanie C.						Complete
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems and current relationship with	All Pteam	Dee W. / Stephanie C.						Complete
Create a list of the patients who are seen most frequently for behavioral/mental health problems	All Pteam	Dee W. / Stephanie C.						Complete
Create a sub-list of patients with documented SUDs, including substance(s)	All Pteam	Dee W. / Stephanie C.						Complete
Process Mapping and Patient Flows								
Complete intake and screening process at MFS	Stephanie C.							Ongoing
Finalize patient flow at both onboarding patient sites - MFS, CMC	Stephanie C.							Ongoing
Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision points	Stephanie C.							Ongoing
Process Milestones and Reporting								
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM	Dee W.	Stephanie C.						Complete

Deliverable/Milestone	Task Assignments		Q1	Q2	Q3	Q4	Ongoing	Status
Implementation Year 1	**Lead**	**Support**	**7/1/19 - 9/30/18**	**10/1/18-12/31/18**	**1/1/19-3/30/19**	**4/1/19-6/30/19**		
Finalize operational dashboard for measures and measure collection	Stephanie C.							Complete
Present to larger project team for approval and finalization	Stephanie C.							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	Stephanie C.							Complete
Continuously collect and interpret outcome data- **M3**	Data Lead Role							
Review pledged project outcomes with all partners	Data Lead Role							Complete
Schedule quarterly project outcome review	Stephanie C.							Complete
Schedule quarterly report targets and deadlines	Stephanie C.							Complete
Analyze and review 6 months of project outcomes -**M4**	All Pteam							
Review and assess potential supplemental funding opportunities - **M4**	All Pteam							
*Focus on project sustainability								
Comprehensive Core Standardized Assessment								
Continue CCSA development and coordination with IDN1 CCSA Protoc	All Pteam	Dee W./Jessica P.						Complete
Integrate finalized CCSA into existing EMR	All Pteam	Jessica P.						Complete
Integrate CCSA into workflow	All Pteam	Dee W.						Complete
Address coordination with MFS utilization of DLA20	All Pteam	Dee W.						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	All Pteam	Dee W.						Complete
Comprehensive Core Standardized Assessment (Pediatric)								
Determine the developmental screening instrument to be utilized with the CCSA	* Pending Launch with Pediatrics							Complete
Integrate developmental screening into existing EMR								Complete
Integrate developmental screening into workflow								Complete
Shared Care Plan								
Project team demo on SCP portal and needs	Mark B./Jaime D.	Stephanie C.						Complete
Address inclusion of non covered entities on SCP	Mark B./Jaime D.	Stephanie C.						Complete
Budget								
Share quarterly with IDN	All Pteam							Complete
Key Organizational and Provider Participants								
Share formal award notice to all partners and supporting organizations	All Pteam	Dee W.						Complete

Deliverable/Milestone	Task Assignments		Q1	Q2	Q3	Q4	Ongoing	Status
Implementation Year 1	**Lead**	**Support**	**7/1/19 - 9/30/18**	**10/1/18-12/31/18**	**1/1/19-3/30/19**	**4/1/19-6/30/19**		
Document and continually support referral partnerships		Dee W.						Complete
Address any gap areas in partner support network- target through new partner cultivation	All Pteam	IDN						Complete
Address cultural barriers and look to supported IDN trainings on culture change	All Pteam	IDN						Complete
Network Development - M2, M3								
Assign team members to support development and outreach	Dee W.	Stephanie C.						Complete
Continue to expand and develop the network of collaborating organizations	All Pteam	Stephanie C.						Ongoing
Review current process for developing new partner relationships	Dee W.	Stephanie C.						Ongoing
Privacy & Security								
Execute Data Sharing Arrangement with Support Services Organizations **-M2**	Data Lead Role							Complete
*Identify areas where updates or new development is needed								
HIT Implementation								
Deploy Shared Care Plan Application	CMC/MFS IT	IDN Supported						Complete
Deploy Direct Secure Messaging Application	CMC/MFS IT	IDN Supported						Complete
Deploy Event Notification Application	CMC/MFS IT	IDN Supported						Complete
Deploy Clinical Quality Measurement Application	CMC/MFS IT	IDN Supported						Complete
HIT Components Completed and Functional - **M2, M3**		IDN Supported						
Integration Assessment								
Complete SSA at 6, 12, 18 month intervals	Stephanie C.							Complete
review	Stephanie C.							Complete
Evaluation								
At 6 month intervals measure	Dee W.	Stephanie C.						Complete
# of external community support referals from B1 team	Dee W.	Stephanie C.						Complete
Progress towards coordinated care practice designation	Dee W.	Stephanie C.						Complete
Data Sharing								
Outcome data accumulated and reviewed	Stephanie C.	Dee W.						Complete
Share SSA Integration levels with B1 provider cohort	Stephanie C.	All Pteam						Complete
*Support IDN efforts for data transparency through reporting and project outcomes presenentation								
Meetings and Reports								
Documented minimum requirement met quarterly	Reporting Lead	Stephanie C.						Ongoing
Knowledge Exchanges and IDN Involvement								
Share key learnings with IDN1 partners and participation quarterly	All Pteam	Stephanie C.						Ongoing
Use of Funds								
Appropriate use of project funds used monthly and actuals reported quarterly	Reporting Lead	Stephanie C.						Ongoing
Accountability of Time								
Accountability for use of staff time to serve project functions reported quarterly	Reporting Lead	Stephanie C.						Ongoing

Appendix B1-2: APD

Deliverable/Milestone	Task Assignments		PRE-Q1	Q1			Q1	Q2	Q3	Q4	Status
IMPLEMENTATION YEAR ONE	**Lead**	**Support**	**10/17-12/18**	**Jan, 2019**	**Feb, 2019**	**Mar, 2019**	**1/1/19-3/30/19**	**4/1/19-6/30/19**	**7/1/19-9/30/19**	**10/1/19-12/31/19**	
Meeting with QI facilitator & IDN leadership to launch project	Jessica P.	Stephanie C.									Complete
Complete contracting process and submit	Brian L.	Jessica P.									Complete
Create Behavioral Health Sepcialist job description	Colin S.	Brian L.									Complete
Identify B1 work team members	Brian L.	Lauren S.									Complete
Identify ongoing work team meeting dates/time	Sarah L.	Stephanie C.									Complete
Meeting with APD team for introduction of project	Jessica P.	Stephanie C.									Complete
Charter Completion- Final review and approval by all project team members	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 and suport attendance across partner agencies	Sarah L.	Stephanie C.									Complete
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	Stephanie C.	Colin S.									Complete
Set up recurring MDCT meetings monthly and case assessment process	Sarah L.	Stephanie C.									Complete
Recuit to Hire											
Document weekly progress toward position hiring and share with broader project team membership	Colin S.	Lauren S.									Complete
Share job descriptions and links to postings with all project team members	Colin S.	Lauren S.									Complete
Assign team member lead support for communication of progress and interview panel updates	Colin S.	Lauren S.									Complete
Onboarding											
Formalize and document the onboarding and training process for new positions	Colin S.	Lauren S.									Complete
Create a training plan by needed position to share and replicate for subsequent hires	Jessica P.	Colin S.									Complete
Address with project team onboarding activities to be supported by the IDN staff and partner network	Jessica P.	Colin S.									Complete
Training											
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	Stephanie C.	Shelley/Sarah									Complete
Train MDCT in roles and responsibilities	Stephanie C.	Shelley/Sarah									Complete
Train MDCT in use of SCP and secure messaging	Jaime D.										Complete
Train community partners in use of SCP and secure messaging	Jaime D.	All Pteam									Complete
Train patients and families in use of SCP- IDN Supported	IDN Supported	All Pteam									Complete
Determine physical health, mental health and SUD topics for MDCT training	Jessica P.	BHS									Complete
Decide on standardized, evidence-based training materials	IDN Supported										Complete
Develop training schedule, including update schedule	Stephanie C.	Colin S.									Complete
Train all staff in cultural sensitivity and destigmatization	IDN Supported										Complete

Deliverable/Milestone	Task Assignments		PRE-Q1	Q1			Q1	Q2	Q3	Q4	
IMPLEMENTATION YEAR ONE	Lead	Support	10/17-12/18	Jan, 2019	Feb, 2019	Mar, 2019	1/1/19-3/30/19	4/1/19-6/30/19	7/1/19-9/30/19	10/1/19-12/31/19	Status
Offer annual training to all project team membership on chronic disease management in the following domains:	IDN Supported										Complete
Diabetes Hyperglycemia	IDN Supported										Complete
Dyslipidimia	IDN Supported										Complete
Hypertension	IDN Supported										Complete
Mental Health Topics (Mulitple)	IDN Supported										Complete
SUD Topics (Multiple)	IDN Supported										Complete
Offer basics of mental health first aid to practice billing and reception staff annually	IDN Supported										Complete
Target Population-M2											
Create a registry of Medicaid beneficiaries at APD Primary Care	Colin S.										Complete
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems	Colin S.	Jess O.									Complete
Create a list of the patients who are seen most frequently for behavioral/mental health problems	Colin S.	Jess O.									Complete
Create a sub-list of patients with documented SUDs, including substance(s)	Colin S.	Jess O.									Complete
Process Mapping and Patient Flows											
Complete intake and screening process at APD	Stephanie C.	Sara									Complete
Finalize patient flow at both onboarding patient sites - APD											Complete
Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision points	Jessica P.										Complete
Process Milestones and Reporting											
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM	Colin S.	Brian L.									Complete
Finalize operational dashboard for measures and measure collection	Stephanie C.	Jaime D.									Complete
Present to larger project team for approval and finalization	Stephanie C.										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	Stephanie C.										Complete
Continuously collect and interpret outcome data	Jess O - DHMC										Ongoing
Review pledged project outcomes with all partners	Jess O - DHMC										Ongoing
Schedule quarterly project outcome review	Stephanie C.										Ongoing
Schedule quarterly report targets and deadlines	Stephanie C.										Ongoing
Analyze and review 6 months of project outcomes	All Pteam										Ongoing
Review and assess potential supplemental funding opportunities	All Pteam										Ongoing

Deliverable/Milestone	Task Assignments		PRE-Q1	Q1			Q1	Q2	Q3	Q4	
IMPLEMENTATION YEAR ONE	**Lead**	**Support**	**10/17-12/18**	**Jan, 2019**	**Feb, 2019**	**Mar, 2019**	**1/1/19-3/30/19**	**4/1/19-6/30/19**	**7/1/19-9/30/19**	**10/1/19-12/31/19**	**Status**
*Focus on project sustainability											
Comprehensive Core Standardized Assessment											
Training across B1 teams on CCSA Implementation	Casey	Karry									Complete
Crosswalk these domains with existing demographic, SDOH, and screening instruments currently in use	Pteam										Complete
Integrate finalized CCSA into existing EMR	Pteam										Complete
Integrate CCSA into workflow	Pteam										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	Stephanie C.										Complete
Comprehensive Core Standardized Assessment (Pediatric)											
Determine the developmental screening instrument to be utilized with the CCSA	Team										Complete
Integrate developmental screening into existing EMR	Team										Complete
Integrate developmental screening into workflow	Team										Complete
Shared Care Plan											
Project team demo on SCP portal and needs	Jaime D.	Jessica P.									Complete
Address inclusion of non covered entities on SCP	Jaime D.	Jessica P.									Complete
Budget											
Establish use of funds tracking for pilot within current system - IDN	Stephanie C.										Complete
Share quarterly with IDN	Colin S.										Ongoing
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	All Pteam	IDN									Complete
Address cultural barriers and look to supported IDN trainings on culture change	All Pteam	IDN									Complete
Network Development											
Project team review and identification of all formal project partners and community supports	All Pteam										Complete
Assign team members to support development and outreach											Complete
Continue to expand and develop the network of collaborating organizations	All Pteam										Complete
Review current process for developing new partner relationships											Complete
Privacy & Security											
Train Staff on Treatment of Sensitive Patient Information											Complete
Execute Data Sharing Arrangement with Support Services Organizations	Data Lead Role										Complete
*Identify areas where updates or new development is needed											Complete
Linkage to IDN resources and forms											Complete

Deliverable/Milestone	Task Assignments		PRE-Q1	Q1			Q1	Q2	Q3	Q4	
IMPLEMENTATION YEAR ONE	Lead	Support	10/17-12/18	Jan, 2019	Feb, 2019	Mar, 2019	1/1/19-3/30/19	4/1/19-6/30/19	7/1/19-9/30/19	10/1/19-12/31/19	Status
HIT Implementation											
Deploy Shared Care Plan Application	Jaime D.	IDN Supported									Complete
Deploy Direct Secure Messaging Application	Jaime D.	IDN Supported									Complete
Deploy Event Notification Application	Jaime D.	IDN Supported									Complete
Deploy Clinical Quality Measurement Application	Jaime D.	IDN Supported									Complete
HIT Components Completed and Functional	Jaime D.	IDN Supported									Complete
Utilize the IDN suppported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup	Jaime D.	IDN Supported									Complete
Integration Assessment											
Complete SSA at 6, 12, 18 month intervals	Stephanie C.	Jessica P.									Ongoing
Projet team coordination for SSA completion, submission, and review	Stephanie C.	Jessica P.									Ongoing
Evaluation											
Review for inclusion of evidence based practices determined in implementation plan	Jessica P.										Complete
At 6 month intervals measure	Jessica P.										Complete
# of external community support referals from B1 team	Jessica P.										Complete
Progress towards coordinated care practice designation	Jessica P.										Complete
Data Sharing											
Outcome data accumulated and reviewed	Data Lead Role										Complete
Meetings and Reports											
Documented minimum requirement met quarterly	Reporting Lead	Jessica P.									Ongoing
Knowledge Exchanges and IDN Involvement											
Share key learnings with IDN1 partners and participation quarterly	All Pteam	Jessica P.									Ongoing
Use of Funds											
Appropriate use of project funds used monthly and actuals reported quarterly	Reporting Lead	Jessica P.									Ongoing
Accountability of Time											
Accountability for use of staff time to serve project functions reported quarterly	Reporting Lead	Jessica P.									Ongoing
Project Defined Milestones											
Milestone: Q1											
Develop work group for project implementation											Complete
Milestone: Q2											
Hire for position(s)											Complete
Milestone: Q2, Q3											
Adapt clinic work flow and processes for implementation											Complete
Milestone: Q2											
Develop Partnership Agreement with counseling service provider											Complete

Milestone: Q2, Q3											
Develop Standardized Workflows and Protocols											Complete
Milestone: Q2, Q3											
Create protocols to ensure safe care transitions from institutional settings											Complete
Milestone: Q3											
Implement Shared Care Plan											Complete
Milestone: Q3											
Implement Standardized Workflows and Protocols											Complete
Milestone: Q4											
Implement process for follow up after ED visit or hospitalization											Complete
Milestone: Q4											
Screening implemented across PCP office											Complete
Milestone: Q4											
Implement protocols to ensure safe care transitions from institutional settings											Complete
Milestone: Q4											
Comprehensive and consistent use of standardized core assessment framework											Complete

Appendix B1-2: NHC

		NHC 2019 Launch of Pediatrics & Adults	J	F	M	A	M	J	J	A	S	O	N	D
QUARTER ONE	Milestone #1	**Comprehensive Core Standardized Assessment (CCSA)** ***aka Patient Questionnaire***												
	Objective 1A:	Identify and approve CCSA tool for youth screening												
	Objective 1B:	Identify and approve CCSA tool for parent/guardian screening												
	Objective 1C:	Create pathways to address CCSA questions for each patient type												
	Objective 1D:	Process mapping update for future state & CHW inclusion												
	Objective 1E:	Launch pediatric CCSA to R. Lozman-Oxman's patients: **nonacute visits only**												
	Objective 1F:	Training on purpose and use of Plan, Do, Study, Act (PDSA) cycles												
	Objective 1G:	Create and approve adult CCSA												
	Objective 1G:	Complete PDSA cycle on CCSA workflow and identify gaps; role of MSW & CHW												
	Objective 1H:	Complete PDSA cycle on CCSA database and analysis of data												
	Objective 1I:	Combine CCSA PDSA cycles for a STAFFING IMPACT evaluation/analysis; identify gaps												
	Milestone #2	**Multi-Disciplinary Care Team (MDCT)** ***aka Provider Meetings***	J	F	M	A	M	J	J	A	S	O	N	D
	Objective 2A:	Review and approve Special Consent for Pediatrics												
	Objective 2B:	Create and approve procedures for MDCT												
	Objective 2C:	Training and scheduling of MDCT and trial run with agenda and mental health providers												
	Objective 2D:	Complete PDSA cycle of MDCT and identify gaps												
	Objective 2E:	Training on use of Shared Care Plan												
	Objective 2F:	Evaluate PDSA cycles for MDCT/SCP for STAFFING IMPACT evaluation/analysis; identify gaps												
QUARTER TWO	Milestone #3	**Expansion of Initiative to Primary Care Providers**	J	F	M	A	M	J	J	A	S	O	N	D
	Objective 3A:	Introductory Luncheon Presentation to all primary care providers and staff; Monday, April 1st												
	Objective 3B:	Expand project to **nonacute, annual visit adult patients** served by Melissa Nelson, NP												
	Objective 3C:	Expand project to **nonacute, annual visit adult patients** served by Nicole Poudrette,FNP												
	Objective 3D:	Complete PDSA cycle for 3B and 3C												
	Objective 3E:	Expand project to **nonacute, annual visit adult patients** served by Shannon Schachtner, PA												
	Objective 3F:	Expand project to **nonacute, annual visit adult patients** served by Ben Holbowciz,PA												
	Objective 3G:	Expand project to **nonacute, annual visit adult patients** served by Schissel/Herfort												
	Objective 3H:	Complete PDSA cycle for 3E, 3F, 3G												
	Objective 3I:	Evaluate PDSA cycles for all providers for STAFFING IMPACT evaluation/analysis; identify gaps; expanded role of MSW and use of CHW												
	Objective 3J:	Identify role of on-staff psychiatrist in progam												
QUARTER THREE	Milestone #4	**Evaluate Quality Reporting and Program**	J	F	M	A	M	J	J	A	S	O	N	D
	Objective 4A:	Evaluate quality reporting requirements for Components 1 & 3												
	Objective 4B:	Evaluate quality reporting requirements for Components #2												
	Objective 4C:	Evaluate quality reporting requirements for Components 4 & 5												
	Objective 4D:	Evaluate quality reporting requirements for Components 6, 7, and 8												
	Objective 4E:	Analyze staffing impact and delivery of model on patient care; efficiencies												
	Objective 4F:	Create process integration plan for on-site psychiatrist												
QUARTER FOUR	Milestone #5	**Sustainability**	J	F	M	A	M	J	J	A	S	O	N	D
	Objective 5A:	Confirm adult patients and well-child pediatrics involved in program, all practices, all providers												
	Objective 5B:	Complete PDSA cycle for 3E												
	Objective 5C:	Confirm successful integration of on-site psychiatrist in program												
	Objective 5D:	Complete PDSA cycle for 3C												

Appendix C-1

Deliverable/Milestone	Task Assignments		Ongoing
Implementation Year 1/2	Lead	Support	
Recruit to Hire Coordinator Staff - M1, 2			
Finalize job description- Review by all team members and facilitators			
Address hiring process with MFS, MC			
*Outline timeline for internal hiring processes and projected date to hire			
Assign team support for job posting, resume review, and interview scheduling			
Identify interview panel members			
*Address tie-ins to workforce loan repayment planning			
Formalize E5 Coordinator Training plan (onboarding process and length)			
*Include PHI Privacy and 42 CFR Pt. II needs			
Revise timeline process for date of hire to direct patient support			
Project Team Development- M2			
Email to all partners notifying of project award			
Schedule and plan for all-partner meeting			
Review partner roles : any need for additional support on project team	Phil	Kate C	
Review community service organization partners and address any gaps	Phil	Maryanne	
*Opportunity to address current referral and assessment gaps, high functioning processes, and technology capacity of partner entities			
Schedule recurring parter meetings (quarterly or semi-annual)			
Environmental scan for overlap with other Cheshire County projects, networks and coordinated meetings			
* IDN requirements will be met with leveraging existing structures			
Patient Identification and Screening - M2			
Identify priority data fields for screening	Phil / Team	Mark B	
Coordinate with B1 Planning Team at CMC (E5 Overlap)	Phil	Maryanne	

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			
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			
Coordinate with HIT B1 implementation			
Address Shared Care Plan usage			
*Leverage adoption and training support from other initiatives			
Screening and Assessment Tool Development -M2			
Review of current tools across partner network			
Review of CTI case management toolkit			
Map end-to-end orocesses for CTI tailored to Cheshire sub-region			
Identify patient assessment protocols and tools			
Identify patient management protocols			
Identify referral process and tools			
Referral and Assessment process development- **M2**			
Outcomes Measurement - M			
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			
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			
CTC Supervisor participation in November and December CTI 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)			
Linkage to IDN resources and forms			
Execute data sharing agreements with partners, MOUs -**M**			
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			
Identify Participating Support Services Organizations			
Formalize Relationship with Support Services Organizations			
Build Awareness of new Resources Among Hospital Key Personnel			
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 suppported 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 requirment 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	Ongoing
Implementation Year 1	
Charter Completion- Final review and approval by all project team members	
*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	
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	
Recuit to Hire - M1, 2	
Document weekly progress toward position hiring and share with broader project team membership	
Share job descriptions and links to postings with all project team members	
Assign team member lead support for communication of progress and interview panel updates	
Onboarding and Training	
Formalize and document the onboarding and training process for each new role	
*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	
*Address privacy and consent training for role within IDN SCP	
Creation of staffing schedule	
Process Milestones and Reporting	
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM	
Finalize operational dashboard for measures and measure collection	
Present to larger project team for approval and finalization	
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	
Continuously collect and interpret outcome data- **M3**	

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	
Training	
Develop and offer CBT training for applicable project staff	
Develop and offer DBT training for applicable project staff	
Develop and offer Motivational Interviewing/Enhancement training for applicable project staff	
Develop and offer Relapse prevention for applicable project staff	
Offer Circle of Security training for IOP staff	
Determine prioritized training guide and align with project timeline (address topics above and below)	
Offer Specific Trainings to Staff	
Prenatal care	
SUD-specific prenatal education:	
Risks of substance exposure, inclusive of tobacco/marijuana	
Managing pregnancy-associated side effects of MAT (primarily nausea and constipation)	
Optimizing nutrition during pregnancy and breastfeeding	
Neonatal abstinence syndrome: diagnosis, management, aftercare	
Pregnancy, HCV and/or HIV testing	
Breastfeeding and MAT	
Hospital drug testing policies	

Mandated reporting and the Plan of Safe Care	
Not pregnancy-focused	
Screening and treatment for sexually transmitted disease, including partner treatment	
Safe sex counseling, including condom distribution	
Cervical cancer screening	
Hepatitis and HIV education, screening, and referral	
Pregnancy testing, options counselling, and access to abortion care (referrals)	
Tuberculosis testing	
Counselling for pregnancy intention	
Influenza vaccination	
Domestic violence screening	
Tobacco use counselling and treatment	
Reproductive health education	
Curriculum development for pregnant and parenting women	
Case management training	
Psychiatric Assessment - Protocol development	
MAT development	
* 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	
Document participation guidelines	
Develop family support childcare guidelines	
IOP Initial curriculum development **- M2**	
Formalize with project team support and roll up into program operations bundle	
Implement 6 month tollgates for materials review (curriculum, protocols etc.) - **M3**	
Finalized Curriculum- **M4**	
Budget	
Establish use of funds tracking for pilot and within current system	
*Address unique DGR project code for salaries and expenditures	
Create funding matrix to show IDN funded areas and other supported positions, activities	
Ongoing review of sustainable funding sources- **M4**	
Establish use of funds tracking and budget table	
Share quarterly with IDN	
Key Organizational and Provider Participants	
Share formal award notice to all partners and supporting organizations	
Document and continually support referral partnerships	
Address any gap areas in partner support network- target through new partner cultivation	
Patient Advisory Board- Determine meeting frequency, membership- **M2**	
Network Development - M2, M3	
Develop outreach and program marketing campaign	
Assign team members to support development and outreach	
Continue to expand and develop the network of collaborating organizations	
Review current process for developing new partner relationships and	
Assessment and Screening Tools	
Develop with Project Team Scope of Work assessment and screening minimum requirements	

Utilize a comprehensive core assessment and a care plan for each enrolled paitent, updating regularly	
Coordintate with the B1 projects for SCP and CCSA Analysis	
Determine screening used for client triage and caseload assignment	
Institute continous improvement and review of the referral process functionality	
Set up Referral to Recovery Supports process	
Set up Referral to Counseling process	
Set up Inbound Referral process	
Privacy & Security	
Train Staff on Treatment of Sensitive Patient Information	
Execute Data Sharing Arrangement with Support Services Organizations **-M2**	
Review current PATP consent and privacy forms	
*Identify areas where updates or new development is needed	
Assess current VRH processes and forms	
Coordinate with B1 Planning Team at VRH	
Linkage to IDN resources and forms	
Execute data sharing agreements with partners -**M**	
HIT Implementation	
Deploy Shared Care Plan Application	
Deploy Direct Secure Messaging Application	
Deploy Event Notification Application	
Deploy Clinical Quality Measurement Application	
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 suppported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup	
Launch Services- M2, M3	
Create timeline for program expansion rollout from Monday to Thursday clinical implementation	
Identify population of Medicaid-eligible women with substance use disorders who meet criteria for ASAM level 2.7 services	
Implement evidence-based, trauma-focused curriculum	

Implement co-location model	
Provide Comprehensive Screening/Intake Assessment	
Provide Care Planning including addressing all ASAM domains, medical, and psychiatric needs	
Operate 8-week IOP Treatment Model toIInclude the following:	
Provide Referrals to Counseling	
Provide Referrals to Peer Supports/Recovery Coaches	
Provide Referral to Smoking Cessation Support	
Recieve Inbound Referrals	
Provide Life Skills Programming	
Provide Urine drug screens and breathalyzer testing	
Provide continuing services post 8-week IOP	
Expand Childcare Model- M2, 3	
Expand current childcare model	
Provide childcare during group sessions	
Address formalizing priority criteria for supporting participants with childcare	
Business Case	
Develop initial Business Case for Scaling the IOP model	
Test and Refine Business Case for Scaling the IOP model	
Evaluation	
Establish 2018/2019 program objectives -**M4**	
Data Sharing	
Address data sharing with PATP, IDN	
Outcome data accumulated and reviewed	
Approve and disseminate data sharing forms to all project partners	
Support IDN efforts for data transparency through reporting and project outcomes presenentation	
Meetings and Reports	
Documented minimum requirment met quarterly	
Knowledge Exchanges and IDN Involvement	
Share key learnings with IDN1 partners and participation quarterly	
Use of Funds	

Appendix E-1

Updated work plan expected for next reporting period due to new position onboarding and expansion of project work

Deliverable/Milestone	Task Assignments		Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
Implementation Year 1	**Lead**	**Support**	**10/1/17-12/31/17**	**1/1/18-3/30/18**	**4/1/18-6/30/18**				
Contract Approval									
Address VRH or IDN barriers to contract approval and release									Position subcontracted with
*Target subcontract payment by 10/31/17									
Recruit to Hire Coordinator Staff - M1, 2									
Finalize job description- Review by all team members and facilitators	JP	AG						6/6/2018	COMPLETE
*Outline timeline for internal hiring processes and projected date to hire									
Assign team support for job posting, resume review, and interview scheduling	JP								COMPLETE
Interview potential hires	JP	AG							COMPLETE
Confirm hiring choice and secure payment delivery method / contracting									
Outreach to Project Partners - M1, 2									
Email to all partners notifying of project award	AG	JP						6/6/2018	COMPLETE
Draft of emails reviewed by Jessica Powell, Ashley Greenfield, and facilitators									
Schedule time at Community Partners Meeting in Newport and Claremont	AG	JP						Ongoing	COMPLETE
Review roles of referral and assessment categories	JP	SG						Ongoing	Included in referral form. Currently being piloted
Review community service organization partners and address any gaps	JP	SG							
								Ongoing	Ongoing during meetings
Schedule recurring parter meetings to occur during monthly Communtity Partners Meetings	JP	SG							COMPLETE
Maintain coordination with Public Health Network and Continuum of Care - **M2**									
Environmental scan for overlap with other Sullivan County projects, networks and coordinated meetings									
* IDN requirements will be met with leveraging existing structures									
Initiate coordinated referral partnership agreement with partners - **M2**									
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**									
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									
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 Agreement"									
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 suppported 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 requirment 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									