



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

**For
Year 3 (CY2018)
2017-12-10 v.27**

**FINAL DRAFT
REGION 1 IDN**

Table of Contents

- Introduction 1
 - DSRIP IDN Project Plan Implementation (PPI) 2
 - Soliciting Community Input: 2
 - Network Development: 3
 - (All Updates for the July-December, 2017 period shared in bullet format) 3
 - Addressing the Opioid Crisis..... 4
 - Governance 5
 - Budget 7
- Project A1: Behavioral Health Workforce Capacity Development 10
 - A1-3. IDN-level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan 10
 - A1-4. IDN-level Workforce: Evaluation Project Targets..... 13
 - A1-5. IDN-level Workforce: Staffing Targets..... 14
 - A1-5: Current Community Project Pilot Staffing 15
 - A1-6. IDN-level Workforce: Building Capacity Budget 17
 - A1-7. IDN-level Workforce: Table of Key Organizational and Provider Participants 19
 - A1-9. Project Scoring: IDN Workforce Process Milestones..... 22
- Project A2: IDN Health Information Technology (HIT)..... 23
- To Support Integration..... 23
 - A2-4. IDN HIT: Evaluation Project Targets 38
 - A2-5. IDN HIT: Workforce Staffing 39
 - A2-6. IDN HIT: Budget 39
 - A2-7. IDN HIT: Key Organizational and Provider Participants..... 45
 - A2-8. IDN HIT. Data Agreement 45
 - A2-9. Project Scoring: IDN HIT Process Milestones 48
- Project B1: Integrated Healthcare 49
 - B1-2. IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan 49
- In addition to the standard data reporting required as part of the B1 Integrated Healthcare Project (see these measures on last page), this proposal will also be tracking and reporting on the following measures: 53
- CTC position hired 53
 - B1-3. IDN Integrated Healthcare: Evaluation Project Targets 64

B1-4. IDN Integrated Healthcare: Workforce Staffing	64
B1-5. IDN Integrated Healthcare: Budget	65
B1-6. IDN Integrated Healthcare: Key Organizational and Provider Participants.....	66
B1-7. IDN Integrated Healthcare: IDN Governance Leadership Sign-off	67
B1-8. Additional Documentation as Requested in B1-8a-8h of the Project Scoring Tool in B1-9	67
B1-8a. CSA Utilization	68
B1-8a. Pediatric CSA Utilization	69
B1-8b. Multi-Disciplinary Core Team Members.....	70
B1-8c. Required Training.....	71
B1-8d.....	72
B1-8e. Multi-Disciplinary Core Team Schedule.....	73
B1-8h. Documented Workflows and/or Protocols: No change from 7/31 Submission	75
Interactions between providers and community based organizations	75
Population to be served:	76
Support Team.....	76
Collaboration.....	76
Integrated Care Team Process Flow	77
Shared Care Plan	78
Timely communication	78
Privacy, including limitations on information for communications with treating provider and community based organizations.....	79
Coordination among case managers (internal and external to IDN)	79
Safe transitions from institutional settings back to primary care, behavioral health and social support service providers	80
Adherence to NH Board of Medicine guidelines on opioid use:.....	81
B1-9a. Report on progress toward coordinated care designation	82
B1-9b.....	83
B1-9c. HIT	84
B1-9d. Workflows: No change since 7/31/17 Reporting.....	86
Referral to Supports	86
“No Wrong Door”	86
B1-9. Project Scoring: IDN Integrated Healthcare Process Milestones and Achievement of Coordinated Care Practice Designation Requirements	87
B1-10. Additional Documentation as Requested in B1-9a - 9d	92

B1-11. Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of <i>Integrated Care Practice</i> Designation Requirements	92
B1-12. Project Scoring: IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation	94
Projects C: Care Transitions-Focused.....	96
C-1. IDN Community Project: Core Components, Process Milestones, Training and Evaluation Project Plans.....	96
C-2. IDN Community Project: Evaluation Project Targets.....	102
C-3. IDN Community Project: Workforce Staffing.....	104
.....	104
C-4. IDN Community Project: Budget.....	104
C-5. IDN Community Project: Key Organizational and Provider Participants	105
C-6. IDN Community Project: Standard Assessment Tools.....	106
.....	106
C-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals.....	106
C-8. IDN Community Project: Member Roles and Responsibilities	108
C-9.....	108
C-10. Project Scoring: IDN Community Project Process Milestones.....	110
Projects D: Capacity Building Focused	112
D-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan	112
.....	115
D-2. IDN Community Project: Evaluation Project Targets	118
D-3. IDN Community Project: Workforce Staffing	120
D-4. IDN Community Project: Budget	120
D-5. IDN Community Project: Key Organizational and Provider Participants.....	121
D-6. IDN Community Project: Standard Assessment Tools.....	121
D-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals.....	123
D-8. IDN Community Project: Member Roles and Responsibilities	123
D-9.....	125
D-10. Project Scoring: IDN Community Project Process Milestones	125
Projects E: Integration Focused	126
E-1. IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan	126

E-2. IDN Community Project: Evaluation Project Targets	129
E-3. IDN Community Project: Workforce Staffing.....	132
E-4. IDN Community Project: Budget.....	132
E-5. IDN Community Project: Key Organizational and Provider Participants	133
E-6. IDN Community Project: Standard Assessment Tools	134
E-7. IDN Community Project: Protocols for Patient Assessment, Treatment, Management, and Referrals.....	134
E-8. IDN Community Project Member Roles and Responsibilities.....	135
E-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3	136
E-10. Project Scoring: IDN Community Project Process Milestones	138
Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning	139
APM-1. Project APM Scoring: IDN Participation in Statewide APM Taskforce and Implementation Plan Development and IDN APM Implementation Plan	139
DSRIP Outcome Measures for Years 2 and 3	141

Introduction

The Centers for Medicare and Medicaid Services (CMS) approved New Hampshire’s application for a five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs are charged with participating in statewide planning efforts and selecting and implementing community-driven projects. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings.

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

Submission of the semi-annual report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints your attachments should also be uploaded separately in the original file version as well (MS project, MS excel, etc.) Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable for which it is being submitted. See below for illustration of attachment for project B1 deliverable 2A:

Attachment_B1.2A

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

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

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DSRIP IDN Project Plan Implementation (PPI)

Each IDN was required to develop implementation plans for the July submission. Using Microsoft Project or similar platform, provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics. Please use the format submitted in the July submission to, at a minimum, identify progress made.

See IDN1 Budget Actuals Table in the Budget Section Below

DSRIP IDN Process Milestones

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

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

Soliciting Community Input:

Gaining community input has been foundational to all IDN-1 planning since the beginning of the 1115 Waiver program in Region 1. Leaders across IDN-1 recognize the importance of listening to key stakeholders to understand the complexities of the current system of care and of engaging these stakeholders to plan and implement the changes they would like to see. Initial engagement efforts included

- Comprehensive Behavioral Health Needs Assessment (Completed in 2016)
- Community Members in Governance Roles (Ongoing)
- Community Members in Project Selection Roles (Ongoing)
- Community Member input to Integration Design (Ongoing)
- Listening Tour (First Round in 2017, 2nd Round with B1 Partners in 2018)

During the period of July to December 2017, the Region 1 IDN team continued with the following activities to continually 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

Network Development:

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

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

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

Updates for Semi Annual Period: July-December, 2017

- Continuation of partner outreach and engagement

Identification of Integrated Core Team Partners: IDN-1 has used Medicaid Claims data to identify the providers that serve the current Medicaid population in region 1. The IDN-1 administrative team worked with DHHS during Spring, 2017 to confirm that the majority of Medicaid Member-serving providers are IDN-1 Partners and that the providers who see large numbers of Medicaid members are intimately engaged with the 1115 waiver program.

Updates for Semi Annual Period: July-December, 2017

- The IDN1 team continued to target new partner involvement in the B1 project focusing on expanded participation across partners with the largest attributed population of Medicaid members
 - Inclusion of The following B1 agencies in the active project cohort
 - Cheshire Medical Center
 - Counseling Associates
 - Valley Regional Hospital
 - Monadnock Family Services

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

Updates for Semi Annual Period: July-December, 2017

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

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

Updates for Semi Annual Period: July-December, 2017

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

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

Updates for Semi Annual Period: July-December, 2017

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

Addressing the Opioid Crisis

In fall of 2016, a systemic gap analysis was performed to determine the extent of the opioid crisis in the Region, existing SUD services, and both the need and the opportunities for expansion. Highest need areas identified in this assessment have addressed IDN-1 ongoing plan strategies to address screening; workforce requirements; barriers to accessing care; professional, institutional and community stigma; referral and coordination processes; documentation and confidentiality issues; multidisciplinary team approaches; levels of care; special needs populations; and shared care plans. Integral to the work in all of these areas is a robust plan for workforce development. Projects are planned for recruitment, retention, education and training. These initiatives are aligned with the statewide workforce plan, and will be coordinated with other IDNs. *See the A1 Implementation Plan section for additional information on these process milestones.*

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

- Support from the Foundation for Healthy Communities to develop a model MAT program at
 - Alice Peck Day Memorial Hospital in partnership with the American Academy for Addiction Psychiatry
 - IDN1 is in continued meetings to engage with APD for B1 project implementation and will align with the internal MAT implementation however possible
 - For expansion of MAT at Dartmouth Hitchcock Memorial Hospital

- IDN1 through the DH/WCBH B1 project is coordinating with all internal DH projects including leveraging internal MAT resources
 - For expansion of MAT at Cheshire Medical Center/Dartmouth Hitchcock Keene
 - IDN1 through the CMC/WCBH B1 project will coordinate with all internal CMC projects including leveraging internal MAT resources
- Cheshire Medical Center received a 3-year, \$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 any potential areas for synergy with IDN projects and goals

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 NHB DAS contract to expand MAT with the Center for Excellence
- Dartmouth- Hitchcock Substance Use Mental Health Integration Initiative

Additionally, IDN-1 membership and staff have participated in MAT expansion training, met with staff from the Center for Technology in Behavioral Health, and worked to develop the Perinatal Addiction Treatment Program in the Region after determining the acuity of this need. *Please see the D3 Implementation Plan section for additional detail on the PATP expansion project.*

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

Governance

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

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

Updates for Semi Annual Period: July-December, 2017

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

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 AC met once for a half day work session in the second half of 2017. The Council has been kept informed and apprised of IDN-1 activity through regular communications, a newsletter, and the IDN-1 website.

Updates for Semi Annual Period: July-December, 2017

- Region 1 continued with scheduled Advisory Council meetings on September 18, 2017
- The following agenda guided the Fall Session:

Time	Topic	Leader
8:30 – 9:00	Networking Coffee	
9:00 – 9:05	Welcome & Introductions	Dennis Calcutt, Executive Committee Chair
9:05 – 9:50	Harbor Homes: Integration and Culture Change Presentation	Carol Furlong, Harbor Homes
9:50-10:15	Current Project Presentations: B1, C1, D3, E5, Statewide Efforts	Admin Lead Team and Project Leaders
10:15 – 11:15	Relational Coordination: Tools to Support Culture Change Workshop	Jody Hoffer Gittel, Brandeis University
11:15– 11:30	Region 1 Implementation Knowledge Exchanges	Admin Lead Team
11:30 – 12:00	Networking Lunch <i>Quality Improvement Facilitators Introductions</i>	Region 1 Admin Team

	Workshop A: Shared Care Plan Demo	Mark Belanger, IT Consultant
12:00 – 12:45	Workshop B: Workforce Strategy Input – Training, Recruitment & Retention	Peter Mason & Rudy Fedrizzi, Workforce Co-Chairs
12:45 – 1:00	Wrap-Up & Next Steps	Dennis C. & Admin Lead Team

Finance Governance: IDN-1 added additional partners to its Finance Committee to enhance the level of expertise around Alternative Payment Model (APM) strategy development. The Committee will now focus on both the budget and development and implementation of an APM in Region 1.

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

Updates for Semi Annual Period: July-December, 2017

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

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. Expense activities in the last six months:

with CMT for Shared Care Planning and Event Notification, Kno2 for Direct Secure Messaging, and the MAeHC Quality Data Center for Data Aggregation and Quality Reporting. All contracts have been executed and deployment is underway with all technical services. See A2 Implementation Plan for additional details.

Updates for Semi Annual Period: July-December, 2017

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

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 3 waves of assessment over the course of the next 18 months. This initial assessment will serve as the framework for the ongoing B1 rollout. Additionally, this subcontract will pay for quality improvement coach support across the B1 practices implementing in each wave. See B1 Implementation Plan section for additional details.

Updates for Semi Annual Period: July-December, 2017

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

Training: IDN 1 has aligned support for Hunter College CACTI with 4 other regional IDN's to bring CTI training to the state of NH. Also, the IDN has participated in the Privacy Boot camps to many of the ongoing efforts and process milestones identified in the A1 Implementation Plan speak to the regional emphasis on offering IDN supported training and the value in collaboration statewide to facilitate more training availability.

Project A1: Behavioral Health Workforce Capacity Development

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

See attachment A1-3a for IDN1 Workforce Implementation Timeline

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.

Using Microsoft Project or similar platform, provide a detailed narrative which provides progress made on required activities, timelines, milestones, progress assessment check points, and evaluation metrics.

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

At a minimum provide detail on the progress made on the strategies to address identified workforce gaps in:

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

The Region 1 team focused its regional workforce efforts during the first few months of this reporting period on staffing the four projects and providing necessary training to the new hires and newly formed teams. Though the recruitment to hiring phase took longer than anticipated for all positions, Region 1 successfully filled thirteen out of fourteen needed positions across the four project teams. Upon hiring the new personnel, all teams immediately shifted to providing the new hires and new teams with the trainings required to implement the specific projects. Region 1 is continuing to actively recruit for open project positions through multiple avenues. (Please see sections B1: Integrated Healthcare and C1, D3, E5: Community Project sections for more specific details).

As the project teams progressed, Region 1 reorganized its Workforce Workgroup in November, 2017 to include representation from a broader net of IDN1 partners to solicit direct input on how to allocate the general workforce dollars (non-specific to project teams) earmarked for Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, Peer Recovery Support and Partner Capacity Support. Through an all-partner workforce discussion in November followed by the a Workforce Workgroup meeting in December with the new membership, the Region 1 Administrative Leads team socialized a Request for Award (RFA) process with predetermined "buckets" for the above-mentioned categories to promote general workforce development across the region. The team desired consensus-driven input from its partners across all sub-regions prior to releasing a RFA – the administrative leads wanted to hear directly from the partners on what breakdown of monetary awards in these categories would prove impactful. The IDN will be releasing a RFA in early 2018 to invest about 50% of the identified funds associated with these recruitment, retention and capacity building categories, and then will re-evaluate the impact at the end of

the next reporting period. (Region 1 is choosing to be conservative until the uncertainty around the 1115 waiver funding is resolved).

Additionally, as Region 1 had taken a decentralized approach to hiring for the Integrated Healthcare and Community projects, the Workforce Workgroup took a step back to consider a thoughtful and cohesive recruitment and retention strategy across all three sub-regions included in Region 1. Partners across the region wish to invest in a collaborative social marketing campaign which attracts behavioral health workers to all of the sub-regions by highlighting the different vantage points of each distinctive geography. This effort would help to deter “poaching” and competition from organization to organization or sub-region to sub-region of qualified candidates. The Workforce Workgroup will continue in 2018 to develop this “Region 1 is open for business” strategy and address how to leverage recruitment and retention funds to market open behavioral health positions across the region and promote a unified marketing approach. Tactics associated with this approach will include the existing milestones of hosting career fairs, continuing partnerships with regional universities and community colleges, holding behavioral health workforce celebrations, leveraging the Region 1 IDN website to post links to open DSRIP-funded positions from all partners and developing partnerships with large employers (including non-healthcare) across the region to sync efforts to recruit “trailing partners” as well as connecting with Stay Work Play NH. Additionally, Region 1 will partner with other IDNs to align similar efforts across the state as all IDNs recognize the value in streamlining these social marketing activities to meet the Recruitment, Hiring, Retention and Sustainability objectives of the Statewide Workforce implementation plan.

Region 1 continues to support all Statewide Workforce Taskforce activities, currently serving on three of the four sub-committees, and attending all statewide meetings. Region 1 supports any opportunity to centralize cross-IDN efforts to improve workforce capacity through the statewide objectives outlined in the implementation plan. Additionally, 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 actively participated 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 Society
- 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)

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 ongoing; discussions with Region 1 partners are ongoing regarding their training needs. Additionally, Region 1 conducted its second training inventory of all partners to identify key trainings desired across the region, number of employees needing each training and available in-house trainings that could be leveraged to train additional Region 1 partners as well as members of other regions. Region 1 had eight partners respond to this survey and only a few common themes emerged. However, Region 1 is already working to address most of the requested trainings relevant to the 1115 Waiver which included best practices for integrated care, certified recovery support workers, smoking cessation, alternative payment models, MAT, and SBIRT. For additionally requested trainings such as vocational training, combatting bullying or in-depth training for autism in adults, the Region 1 team will need to explore opportunities to meet these needs at the Statewide Taskforce and locally. None of these 8 respondents had in-house trainings they were able to share regionally or statewide.

Discussions have been held statewide, and at the local level, with educators and community mental health providers regarding existing competencies in identifying and treating substance use disorders, as well as in the team approach to providing care. Training modules have been identified at Antioch NE that can be incorporated into professional training programs, and additional modules, for more general distribution, are being developed at Geisel School of Medicine at Dartmouth. Region 1's Medical Director is also working with CHI/JSI to develop an Addiction 101/MAT "roadshow" to take to primary care practices. A model demonstration project in overcoming barriers to MAT expansion in primary care practices is well underway at the Multispecialty Clinic at Alice Peck Day Memorial Hospital.

Region 1 has actively participated in the Education and Training Statewide Subcommittee's meetings focused on determining which organizations will take responsibility for maintaining an education and training calendar, as well as an updated resource list of institutional resources and speakers on relevant topics. Once this is accomplished, the results will be disseminated throughout the region. Region 1 hosted two all-partner Knowledge Exchanges in October and November focused on integration, cultural of change, change management and shared care plans. Subsequent Knowledge Exchange Trainings in the first half of 2018 will address the needs of both clinical and non-clinical staff. All of Region 1's Care Transitions team members have attended the Critical Time Intervention Trainings provided in conjunction with the other IDNs. Also, Region 1 project team members have access to CHI/JSI's SBIRT and Motivational Interviewing trainings.

The AHECs are key to efforts to promote behavioral health careers among middle and high school students and college students. In discussion with them, Region 1 identified existing programs it will be accessing and evaluating their potential in meeting the relevant workforce goals.

A celebration of behavioral health, "No Health without Mental Health," was held at DHMC, and similar events are anticipated in other parts of our Region. These events will involve Change Direction NH to promulgate their "5 Signs" program and suicide prevention.

The Region 1 team has determined that adequate existing capacity exists for Recovery Coach training through NHADACA, and will be committing IDN dollars to support regional partners in this initiative.

Region 1 waited to invest in Mental Health First Aid trainings as IDN 2 was working to offer this training for members of all regions. IDN 2 has just tentatively scheduled this training for April 2018 and has offered multiple slots for each IDN; Region 1 will send as many as allowed to this intensive train the trainer week long session and then develop a timeline for these newly trained partners to train other members in Region 1.

Region 1 is also currently involved in ongoing discussions with the Center for Technology in Behavioral Health regarding their resources for training and treatment. Additionally, Region 1 has participated in the Statewide Retention and Sustainability Sub-Committee discussions around the opportunities and cost to employing tele-psychiatry; the committee is early in these discussions.

Region 1’s Medical Director and Director of Technology attended the cross-regional 42 CFR Part II trainings held by NH Citizens Health Initiative. The IDN1 team is providing privacy & security advisory support to all Partners with the goal of supporting expanded information sharing among IDN1 partners through these partner trainings.

Recruitment and Retention

The Region 1 team has met with the human resource directors and CEOs of the primary behavioral health providers in the Region to understand the challenges they face in recruitment and retention of staff, as well as access issues and leveraging the skills of existing providers. It is clear that much of the progress will depend on changes in the state’s licensing and reciprocity processes, and in improvement in provider reimbursement from all the payers. Nevertheless, Region 1 IDN is looking at regional strategies that include convening a meeting of HR directors from major employers to implement a trailing partners program, providing financial support for supervision of trainees, supporting a more robust loan repayment program, and developing a single-point behavioral health recruitment website for the Region. The Region has added the Project Coordinator for Workforce Development and Recruitment of Bi-State Recruitment Center to the Workforce Workgroup, and she has been participating in all strategy meetings.

The IDN is evaluating salary and benefit standards across the Region, as well as practice cultural characteristics, which will inform efforts to retain staff. Additionally, the Workforce Workgroup is entertaining ongoing conversations on exploring alternative funding sources, including philanthropy, to provide financial incentives for retention.

Region 1 offered to financially support up to 10 partner organizations to attend the Bi-State Recruitment and Retention Conference in December. Two partners and one administrative lead member attended the conference and will be sharing the learnings and best practices in Human Resources personnel-focused workforce discussion in February.

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

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

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

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

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 organization's websites.		
Interviews with "Trailing Partners"	Up to 10	3		
Applications for Loan Repayment	Up to 20	0		
Culture Change/Integration education sessions	4	3		
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		
Educational institutions engaged in the workforce expansion project	3	3		
Meetings with IDN's and AHECs on statewide strategies	2	3		
Collaborative practice curriculum for students implemented at professional schools	Up to 4	1		

A1-5. IDN-level Workforce: Staffing Targets

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

Region 1 IDN implemented a decentralized approach to hiring for the IDN projects. Thus, the Region 1 team supported its partner organizations invested in projects in the necessary recruitment and hiring efforts to staff projects during this past reporting period. Region 1 succeeded in fully staffing all of its current projects with the exception of 1 position (explained below and in the Community Project section). Simultaneously, discussions continued at the Workforce Workgroup meetings and in partner discussions on how to address general gaps across our region for behavioral health workforce needs, including MLADCs, psychiatrists and peer recovery coaches. The team is working to address these workforce gaps through recruitment, retention, and education and training strategies at both a state and regional level. Additionally, as the projects progress, Region 1 will examine how to enhance the capacity through revisiting the FTEs needed by the project teams as initial team caseloads increase and dissemination of new practices and workflows continues across provider organizations

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Master Licensed Alcohol and Drug Counselors	Up to 8	0	0		
Behavioral Health Care Coordinators	Up to 6	0	5 (B1/C1/E5)		
Psychiatrists	Up to 4	1 *Indicates shift in current staff time to support IDN project implementation	.3 (D3)		
Psychiatric APRN's	Up to 2	0	0		
Clinical Psychologists/Neuropsychologists	Up to 4	0	0		
Licensed Community Mental Health Counselors and/or Licensed Social Workers	Up to 6	1	1.5 (D3)		
Peer Recovery Coaches	Up to 10	0	.5 (D3)		
AmeriCorps- Community Mental Health Workers	6	* Service Year begins in October, 2017	0		

A1-5: Current Community Project Pilot Staffing

- The D3: PATP – IOP team is fully staffed as projected.
- The C1/E5: Co-Pilot team is fully staffed as projected.
- The E5: Coordinated Entry project experienced hiring constraints related to the care transition coordinator position. Hiring constraints included but not limited to a reduction in FTEs in the organization’s Human Resources department (serving the entire organization’s recruitment needs), competing positions with neighboring organizations, reduction in FTEs in internal department hiring the position (allowing limited time to support the stretched Human Resources department’s efforts). The following efforts are in process to recruit this position:
 - Re-evaluation of position salary
 - Reposting of job position of Idealist, Social Media, Indeed and VRH website
 - Project team partnership with HR and support of position application review

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

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

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

Region 1 reorganized its Workforce Workgroup in November to include representation from more partners to solicit direct input on how to allocate the workforce dollars earmarked for Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, Peer Recovery Support and Partner Capacity Support. Through an all-partner workforce discussion in November followed by the a Workforce Workgroup meeting in December with the new membership, the Region 1 Administrative Leads team socialized a Request for Award (RFA) process with predetermined “buckets” for the above-mentioned categories to promote general workforce development across the region. Our team desired consensus-driven input from our partners across all sub-regions prior to releasing a RFA – we wanted to hear directly from the partners on what breakdown of monetary awards in these categories would prove impactful. Region 1 planned to release a RFA in January to start awarding money within these categories. However, the email from Henry Lipman, Medicaid Director, on December 21st highlighting funding uncertainty temporarily halted our process. Region 1 Executive Sponsors asked our team to hold off on releasing funds (or asking partners to invest time in a RFA process) until more information was obtained on January 5th. Based on the January 5th meeting, the Region 1 Executive Committee voted on January 11th to move forward with a RFA for 50% of the Year 1 Implementation funds in case funding is significantly reduced or ultimately stopped. Thus, the Region 1 team will focus much energy in releasing funds in this next reporting period for general workforce funds related to Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, Peer Recovery Support and Partner Capacity Support. However, at this time, Region 1 has no intention of revising the budget for Year 2.

Training:

- A1 General - \$300 on Recruitment Conference
 - Offered to pay for 10 partners to attend Bi-State Recruitment & Retention Conference in December, 2017. Only two partners attended; invoices for both organizations are still pending but should be attributed to this reporting period
 - \$2750 on training from UNH CHI
 - Privacy & Consent Tech Support
- B1: \$2500 earmarked for training for this reporting period
- C1: \$5,000 for Critical Time Intervention Training; including in the C1 budget
- D3: \$1000 earmarked for Training for this reporting period

Project Title:	A1: Workforce				
Start and End Date:	7/1/2017 to 9/1/2020				
Budget					
	Year 2	Year 2 Actuals	Year 3	Year 4	Totals
	7/1/2017	7/1/2017 - 12/31/2017	7/1/2018	7/1/2019	Totals
Recruitment					
Annual Job Fair	\$2,000.00		2,000	2,000	
Workforce Conference	\$3,000.00				
Supportive Technology	\$1,500.00		\$1,500.00	\$1,500.00	
Loan Repayment					
Support to BH Positions	\$165,000.00		\$165,000.00	\$165,000.00	
Retention					
Training Programs for Retention	\$10,000.00		\$10,000.00	\$10,000.00	
Community Forums					
Mental Health Day	\$1,000.00		\$1,000.00	\$1,000.00	
Supervision Support					
*Funding available for Project Teams	\$125,000.00		\$125,000.00	\$125,000.00	
Internship Support					
* Funding available for Partner agencies	\$100,000.00		\$100,000.00	\$100,000.00	
Entry Level Position Support					
*Funding available for Partner agencies	\$275,000.00		\$275,000.00	\$275,000.00	
Education					
Interprofessional Collaborative Practice Curriculum for PC and BH Students	\$5,000.00		\$5,000.00	\$5,000.00	
	\$25,000.00		\$25,000.00	\$25,000.00	
Peer Recovery Support					
	\$75,000.00		\$75,000.00	\$75,000.00	
Partner Capacity Support for Intern					
	\$50,000.00		\$50,000.00	\$50,000.00	
Training					
*Numerous Categories (SBIRT, MAT etc. - See Narrative)	\$250,000.00	\$2,750.00	\$150,000.00	\$150,000.00	
Training for Patients and Families fo	\$5,000.00		\$5,000.00	\$5,000.00	
Mental Health First Aid	\$5,000.00		\$5,000.00	\$5,000.00	
Total	\$1,097,500.00	\$2,750.00	\$994,500.00	\$994,500.00	\$3,089,250.00

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.

Region 1 on-boarded two new partners in this past reporting period:

- Counseling Associates
- Mascoma Community Health Center

No other changes occurred in Region 1's partnerships during the second half of 2017.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Alice Peck Day Memorial Hospital	Hospital Facility	A1, A2, B1
Cheshire County (includes :)	County	A1, A2
Behavioral Health Court Program (CCBHCP)	Other County Organization	A1, A2
DOC	County Corrections	A1, A2
Maplewood Nursing Home	County Nursing Facility	A1, A2
Cheshire Medical Center/DHK	Hospital Facility	A1, A2, B1, C1, E5
Child and Family Services	Non CMHC Mental Health Provider	A1, A2, B1
Community Volunteer Transportation Company (CVTC)	Community Based Organization Providing Social and Support Services	A1, A2, C1, E5
Counseling Associates	Non CMHC Mental Health Provider	A1, A2, B1
Crotched Mountain (includes :)	Community Based Organization Providing Social and Support Services	A1, A2, B1
Adult Residential Services	Adult Residential Services	A1, A2
ATECH Services	Assistive Technology Clinical Consultation	A1, A2
Community Care	Community Care Management	A1, A2
Outpatient Services	Specialty Outpatient Clinics	A1, A2
Crotched Mountain School	Residential Treatment	A1, A2
Dartmouth-Hitchcock Primary Care-Lebanon	Primary Care Practice	A1, A2, B1
Dartmouth-Hitchcock Psychiatric Associates	Non CMHC Mental Health Provider	A1, A2, B1, D3
Easter Seals Farnum Center	Substance Use Disorder (SUD) Provider	A1, A2, B1
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
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, B1
Mary Hitchcock Memorial Hospital	Hospital Facility	A1, A2
Mascoma Community Health Center ²	Integrated Healthcare Provider	A1, B1
Mindful Balance Therapy Center PLLC	Non CMHC Mental Health Provider	A1, A2, B1
Monadnock Area Peer Support Agency	Other Organization Type	A1, A2, C1, E5
Monadnock Center for Violence Prevention	Community Based Organization Providing Social and Support Services	A1, A2
Monadnock Collaborative	Other Organization Type	A1, A2, C1, E5
Monadnock Community Hospital	Hospital Facility	A1, A2, B1
Monadnock Family Services	Community Mental Health Center	A1, A2, B1, C1, E5
Monadnock Region System of Care	Non CMHC Mental Health Provider	A1, A2, C1, E5
NAMI New Hampshire	Non CMHC Mental Health Provider	A1, A2, B1
New London Hospital and Medical Group Practice	Hospital Facility	A1, A2, B1
New London Pediatric Care Center Practice	Primary Care Practice	A1, A2, B1
Newport Health Center Practice	Primary Care Practice	A1, A2, B1
Pathways of the River Valley	Home and Community Based Care Provider	A1, A2
Phoenix House	Substance Use Disorder (SUD) Provider	A1, A2, B1
Planned Parenthood of Northern New England - Claremont	Primary Care Practice	A1, A2, B1
Planned Parenthood of Northern New England - Keene	Primary Care Practice	A1, A2, B1
ServiceLink-Grafton County	Other Organization Type	A1, A2
ServiceLink - Monadnock	Other Organization Type	A1, A2, C1, E5

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

- 1 Given the current standing of Hope for NH Recovery Statewide the IDN1 team has been in constant communication with the former HOPE staff in Claremont and are staying connected to the planning processes for returning recovery support services to the Sullivan County community. IDN1 will update the organization table accordingly once an outcome has been reached.
- 2 Mascoma Community Health Center has only been operational since mid-Summer 2017 and is currently building their patient base. IDN1 is working to integrate Mascoma Health into the current projects and looking for areas of alignment wherever possible. 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. Additional information will be available in the upcoming reporting periods.

A1-9. Project Scoring: IDN Workforce Process Milestones

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

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

Project A2: IDN Health Information Technology (HIT)

To Support Integration

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

Executive Summary

The Region 1 administrative team and Partners began deploying health information technology in line with the implementation plan in Q3 of 2017. The biggest successes to date are the launch of the shared care plan, which is now live with the high complexity Medicaid Members of one primary care practice. We have also launched the event notification service which is now live with emergency department and inpatient admission/discharge/transfer events from three hospitals.

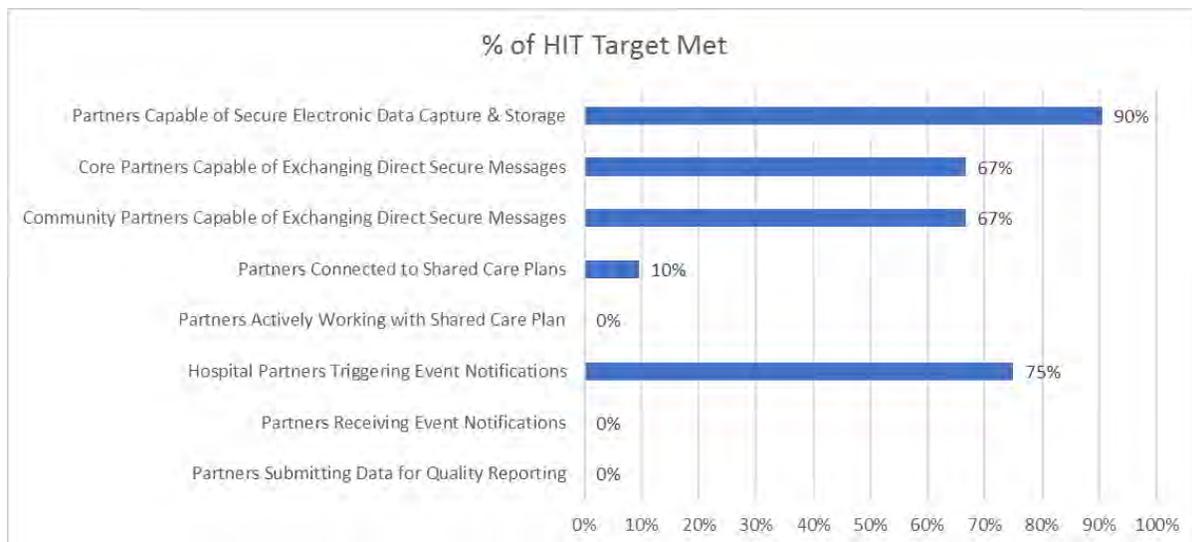
Here are the high points of HIT implementation July – December 2017:

1. Region 1 has successfully vetted and selected projects for deployment in the first wave. Deployment of HIT services has been in tandem with program deployment by the Partner organizations.
2. Region 1 has executed contracts with all technology vendors including: Collective Medical Technologies (CMT) for shared care plan and event notification services, Kno2 for Direct Secure Messaging services (in cases where a Partner's EHR is not capable of Direct), and the Massachusetts eHealth Collaborative (MAeHC) for technical support as well as data aggregation and quality reporting services.
3. Region 1 has facilitated contracting among most of the wave 1 Partner organizations and the technology vendors that require Partner level contracts (CMT, Kno2).
4. Region 1 project teams have defined workflow conventions for screening Medicaid Members, for Shared Care Planning, and for Quality Reporting.
5. Shared Care Plan fields have been defined through a statewide Taskforce and the "New Hampshire Care Recommendations" template has been uploaded in the shared care plans.
6. Technology Vendor CMT has been configured for both Community and Emergency Department use.
7. Data Aggregator Vendor MAeHC has been configured for NH DSRIP measures and reporting requirements
8. Continuous Improvement processes have been put in place for periodic debriefing and improvement of workflow conventions.
9. IDN 1 representatives attended Patient Privacy Bootcamp sessions hosted by Citizens Health Initiative and UNH Law to support the development of a Privacy & Security workbook to aid 42 CFR Part 2 organizations with privacy compliance.
10. Wave 1 Partners have been briefed in patient privacy including the sensitive conditions that may require patient authorization to disclose personal health information under Federal and NH State law.
11. Partners have been offered model documentation for: Notice of Privacy Policy, Patient Authorization for SUD treatment information, and Qualified Services Organization agreements. These are the output from the Privacy Bootcamp sessions held in the summer 2017.

12. All vendor systems have been configured or verified for alignment with the Region 1 privacy approach.
13. Three hospitals (Mary Hitchcock, Valley Regional, Cheshire Medical Center) are live with automatically triggering notifications of emergency department and inpatient admissions, discharges, and transfers.
14. One hospital emergency department (Mary Hitchcock) is accessing shared care plans.
15. All wave 1 Partners have received technical advisory support from the IDN and Region 1 began development of Technical Implementation Guide to support technical components of the program.
16. The Shared Care Plan is live with our first group of high complexity Medicaid Members (Dartmouth Hitchcock – Heater Road Primary Care)
17. Direct Messaging was deployed to Monadnock Collaborative (Service Link).
18. Quality Reporting services deployment is underway with Partners that will be reporting for the 2017 measurement period.
19. The Region 1 Finance Committee has begun to meet regarding Value Based Payment. The Committee has attended the Statewide Learning Collaborative regarding payment reform. HIT leaders have not yet engaged in planning to support a shift in payment methodology and plans to engage beginning in 2019.
20. The Region 1 Data & IT Work Group has met 1-2 times per month throughout the reporting period to guide deployment, to be briefed on project changes, and to share learning.
21. 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, 2017.

Figure 1: Region 1 Progress Relative to HIT Targets as of December 31, 2017



The focus of HIT implementation efforts to date has been the Core Partners of the wave 1 projects. Region 1 HIT deployment is in tandem with project deployment. Each project team has defined process

changes, updated patient privacy policies and processes, defined new roles to hire and train, and moved to implementation. The IT components supporting implementation are:

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

The following dashboard shows the HIT implementation progress to date. 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.

Figure 2: HIT Dashboard - Wave 1 Core Partners

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data
Wave 1						
West Central Behavioral Health	Green	Yellow	Yellow	Yellow	Yellow	Yellow
Dartmouth-Hitchcock Clinic Lebanon	Green	Green	Green	Yellow	Yellow	Yellow
Dartmouth-Hitchcock Psychiatric Associates	Green	Green	Green	Yellow	Yellow	Yellow
Monadnock Family Services	Green	Red	Yellow	Yellow	Yellow	Yellow
Dartmouth Hitchcock Keene - Primary Care	Green	Green	Yellow	Red	Red	Yellow
Valley Regional Hospital - Primary Care	Green	Green	Yellow	Red	Red	Yellow

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

Figure 3: HIT Dashboard - Region 1 Hospitals

Hospital	Sending ADT Messages to ENS	Connected to Pre-Manage ED	Actively Using Pre-Manage ED
Alice Peck Day	Yellow	Red	Red
Dartmouth Hitchcock Keene	Green	Red	Red
Dartmouth Hitchcock Medical Center	Green	Green	Yellow
Monadnock Community Hospital	Red	Red	Red
New London Hospital	Yellow	Red	Red
Valley Regional Hospital	Green	Yellow	Red

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

Work Stream 1: Support Partners in Waves

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

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

Accomplishments:

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

Adjustments to Plan: Wave 2 project selection has been pushed back into Q1 2018.

Upcoming Activity: We anticipate project selection for wave 2 in Q1 of 2018 and will add additional partners to the current HIT deployment activities.

Work Stream 2: Engage Vendors

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

Deliverable/Milestone	Jan-Jun '17	Jul '17	Aug	Sep	Oct	Nov	Dec	Jan '18	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Status	Milestone Reporting Pd	
Work Stream 2: Engage Vendors																						
Complete vendor selection to support IT investments																					Completed	12/31/2017
Milestone: Select vendor for Technical Support																					Completed	6/30/2017
Milestone: Select vendor(s) for shared care plan, Pre-Manage ED, and ENS																					Completed	6/30/2017
Milestone: Select vendor for Direct Secure Messaging Webmail																					Completed	6/30/2017
Milestone: Select vendor for Data Extraction, Validation, and Quality Reporting																					Completed	12/31/2017
Execute contract for Technical Support - Massachusetts eHealth Collaborative																					Completed	6/30/2017
Develop contracts with Vendor and Legal																					Completed	6/30/2017
Milestone: Agreement executed between MAeHC and IDN-1																					Completed	6/30/2017
Execute contracts for Pre-Manage ED / ENS - Collective Medical Technology																					In Progress	
Develop contracts with Vendor and Legal																					Completed	6/30/2017
Milestone: Agreement executed between CMT and IDN-1																					Completed	12/31/2017
Milestone: Agreement executed between CMT and DHMC																					Completed	6/30/2017
Milestone: Agreement executed between CMT and Cheshire Medical Center																					Completed	12/31/2017
Milestone: Agreement executed between CMT and Valley Regional																					Completed	12/31/2017
Milestone: Agreement executed between CMT and New London Hospital																					In Progress	6/30/2018
Milestone: Agreement executed between CMT and Alice Peck Day																					In Progress	6/30/2018
Milestone: Agreement executed between CMT and Monadnock Community Hospital																					Cancelled	12/31/2017
Execute end-user agreements - CMT Pre-Manage Community																					In Progress	12/31/2017
Develop contracts with Vendor and Legal																					Completed	6/30/2017
Facilitate agreements among CMT and Core Partners - Wave 1																					Completed	12/31/2017
West Central Behavioral Health																					Completed	12/31/2017
Dartmouth-Hitchcock Clinic Lebanon																					Completed	6/30/2017
Dartmouth-Hitchcock Psychiatric Associates																					Completed	6/30/2017
Monadnock Family Services																					Completed	12/31/2017
Cheshire Medical Center																					Completed	12/31/2017
Monadnock Collaborative																					In Progress	6/30/2017
Valley Regional Healthcare																					Completed	12/31/2017
Crotched Mountain																					Completed	12/31/2017
Milestone: CMT End user agreements executed by Partners - Wave 1																					In Progress	12/31/2017
Facilitate agreements among CMT and Partners - Wave 2																						6/30/2018
Milestone: CMT End user agreements executed by Partners - Wave 2																						6/30/2018
Facilitate agreements among CMT and Partners - Wave 3																						12/31/2018
Milestone: CMT End user agreements executed by Partners - Wave 3																						12/31/2018
Execute contracts - Kno-2																					In Progress	12/31/2017
Develop contracts with Vendor and Legal																					Completed	6/30/2017
Milestone: Sponsorship agreement executed between Kno-2 and IDN-1																					Completed	6/30/2017
Facilitate agreements among Kno-2 and Core Partners - Wave 1																						12/31/2017
West Central Behavioral Health																					Completed	12/31/2017
Monadnock Family Services																					In Progress	6/30/2018
Monadnock Collaborative																					Completed	12/31/2017
TLC Family Resource Center																					In Progress	12/31/2017
Milestone: Kno-2 End user agreements executed by Core Partners - Wave 1																					In Progress	12/31/2017
Facilitate agreements among Kno-2 and selected Supporting Partners - Wave 1																						12/31/2018
Milestone: Kno-2 End user agreements executed by selected Supporting Partners - Wave 1																						12/31/2018
Facilitate agreements among Kno-2 and Core Partners - Wave 2																						6/30/2018
Milestone: Kno-2 End user agreements executed by Core Partners - Wave 2																						6/30/2018
Facilitate agreements among Kno-2 and selected Supporting Partners - Wave 2																						12/31/2018
Milestone: Kno-2 End user agreements executed by selected Supporting Partners - Wave 2																						12/31/2018
Facilitate agreements among Kno-2 and Core Partners - Wave 3																						12/31/2018
Milestone: Kno-2 End user agreements executed by Core Partners - Wave 3																						12/31/2018
Facilitate agreements among Kno-2 and selected Supporting Partners - Wave 3																						12/31/2018
Milestone: Kno-2 End user agreements executed by selected Supporting Partners - Wave 3																						12/31/2018
Execute contracts - Quality Reporting Vendor - MAeHC Quality Data Center																					Completed	12/31/2017
Develop contracts with Vendor and Legal																					Completed	12/31/2017
Develop list of Participants that will be measured as part of 1115 Waiver																					Completed	12/31/2017
Execute agreement with DHHS for QDC to Receive Attribution Data on behalf of Region 1																					Completed	12/31/2017
Milestone: Agreements executed with Quality Reporting Vendor																					Completed	12/31/2017

Accomplishments:

- Region 1 has executed contracts with all technology vendors including: Collective Medical Technologies (CMT) for shared care plan and event notification services, Kno2 for Direct Secure Messaging services (in cases where a Partner's EHR is not capable of Direct), and the Massachusetts eHealth Collaborative (MAeHC) for technical support as well as data aggregation and quality reporting services.
- Region 1 has facilitated contracting among most of the wave 1 Partner organizations and the technology vendors that require Partner level contracts (CMT, Kno2).

Adjustments to Plan: Vendor contracting with Partner organizations is taking significantly much more time and effort than anticipated. The following wave 1 contracts were not completed in the reporting period and will be completed within the next semi-annual reporting period:

- CMT contracts with Monadnock Collaborative, New London Hospital, and Alice Peck Day
- Kno2 contracts with Monadnock Family Services, TLC Family Resource Center
- Note: Monadnock Community Hospital will not engage for event notification and the CMT contracting activity has been cancelled.

Upcoming Activity: Facilitating Vendor contracting with the remaining wave 1 partners as well as new wave 2 partners.

Accomplishments:

- Region 1 project teams have defined workflow conventions for screening Medicaid Members, for Shared Care Planning, and for Quality Reporting.
- Shared Care Plan fields have been defined through a statewide Taskforce and the “New Hampshire Care Recommendations” template has been uploaded in the shared care plans.
- Technology Vendor CMT has been configured for both Community and Emergency Department use.
- Data Aggregator Vendor MAeHC has been configured for NH DSRIP measures and reporting requirements
- Continuous Improvement processes have been put in place for periodic debriefing and improvement of workflow conventions.

Adjustments to Plan: Workflow conventions are still underway for Inter-Core Team referrals, referrals to supports, and event notification. These activities will slip to Q1 2018. CCSA protocols are still under development and will slip to Q1 2018.

Upcoming Activity: The priority for the next period is to complete the CCSA protocol which includes an ‘off the shelf’ version of the CCSA, Partner training, and associated quality reporting for the Assess measures. Region 1 will also support Partners to complete remaining workflow conventions.

Accomplishments:

- Wave 1 Partners have been briefed in patient privacy including the sensitive conditions that may require patient authorization to disclose personal health information under Federal and NH State law.
- Partners have been offered model documentation for: Notice of Privacy Policy, Patient Authorization for SUD treatment information, and Qualified Services Organization agreements. These are the output from the Privacy Bootcamp sessions held in the summer 2017.
- All vendor systems have been configured or verified for alignment with the Region 1 privacy approach.
- IDN 1 representatives attended Patient Privacy Bootcamp sessions hosted by Citizens Health Initiative and UNH Law to support the development of a Privacy & Security workbook to aid 42 CFR Part 2 organizations with privacy compliance.

Adjustments to Plan: No adjustments to plan.

Upcoming Activity: Continue to rollout briefings, education, and training with wave 2 and wave 3 Partners.

Accomplishments:

- Three hospitals (Mary Hitchcock, Valley Regional, and Cheshire Medical Center) are live with automatically triggering notifications of emergency department and inpatient admissions, discharges, and transfers.
- One hospital emergency department (Mary Hitchcock) is accessing shared care plans.
- All wave 1 Partners have received technical advisory support from the IDN and Region 1 began development of Technical Implementation Guide to support technical components of the program.
- The Shared Care Plan is live with our first group of high complexity Medicaid Members (Dartmouth Hitchcock – Heater Road Primary Care)
- Direct Messaging was deployed to Monadnock Collaborative (Service Link).
- Quality Reporting services deployment is underway with Partners that will be reporting for the 2017 measurement period.

Adjustments to Plan: Wave 1 technology deployments are taking 1-2 months longer than anticipated. This is due mainly to long contracting lead times. Several wave 1 deployments have slipped into Q1 of 2018.

Upcoming Activity:

- Two hospitals (New London Hospital, Alice Peck Day) are completing their contracts to begin triggering event notification.
- One additional hospital emergency department (Valley Regional) is preparing to access shared care plans.
- The Shared Care Plan is to go live with remaining wave 1 Partners (West Central Behavioral Health, Monadnock Family Services, Cheshire Medical Center, Monadnock Collaborative (Service Link), Valley Regional Healthcare) in the next reporting period.
- Direct Messaging is to be deployed with remaining Wave 1 Partners that do not have EHRs capable of Direct (West Central Behavioral Health, Monadnock Family Services, and TLC Family Resource Center) as well as to the community partners engaged in the projects.
- Region 1 will continue to try to engage Monadnock Hospital and their employed ambulatory clinicians for quality reporting.
- Train and support all Partners

Work Stream 6: Preparing for Shift to Value Based Payment

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

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

Accomplishments:

- The Region 1 Finance Committee has begun to meet regarding Value Based Payment. The Committee has attended the Statewide Learning Collaborative regarding payment reform. HIT leaders have not yet engaged in planning to support a shift in payment methodology and plans to engage beginning in 2019.

Adjustments to Plan: No adjustments.

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

Work Stream 7: Oversee Data & IT with Governance

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

Deliverable/Milestone	Jan-Jun '17	Jul '17	Aug	Sep	Oct	Nov	Dec	Jan '18	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Status
Work Stream 7: Oversee Data & IT with Governance																				
Support Frequent Meetings of the IDN-1 Data & IT Workgroup																				
Milestone: Data & IT Work Group Meeting(s) - Jan - June 2017																				Completed
Milestone: Data & IT Work Group Meeting(s) - July 2017																				Completed
Milestone: Data & IT Work Group Meeting(s) - Aug 2017																				Completed
Milestone: Data & IT Work Group Meeting(s) - Sep 2017																				Completed
Milestone: Data & IT Work Group Meeting(s) - Oct 2017																				Completed
Milestone: Data & IT Work Group Meeting(s) - Nov 2017																				Completed
Milestone: Data & IT Work Group Meeting(s) - Dec 2017																				Completed
Milestone: Data & IT Work Group Meeting(s) - Q1 2018																				
Milestone: Data & IT Work Group Meeting(s) - Q2 2018																				
Milestone: Data & IT Work Group Meeting(s) - Q3 2018																				
Milestone: Data & IT Work Group Meeting(s) - Q4 2018																				

Accomplishments:

- The Region 1 Data & IT Work Group has met 1-2 times per month throughout the reporting period to guide deployment, to be briefed on project changes, and to share learning.
- 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 be restructured now that the program has shifted from planning to deployment. The group will be convened quarterly to share learning.

A2-4. IDN HIT: Evaluation Project Targets

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Partners Connected to Shared Care Plans	21	2		
# Partners Actively Working with Shared Care Plans	21	0		
# Partners Receiving Event Notifications	21	0		
# of Partners Submitting Data for Quality Reporting (data feed and/or portal)	21	0		
# of Project B1 Partners Capable of exchanging Direct Messages	21	13		
# of Community Partners Capable of exchanging Direct Messages	9	6		
# Hospital Partners Sending ADT Messages to ENS	4	3		
# Hospital Partners Connected to Pre-Manage ED	3	1		
# Hospital Partners Actively Working with Pre-Manage ED	2	0		

Note: As part of the December 2017 Semi-Annual Report submission IDN-1 has adjusted the target number of organizations to submit quality data from 21 to 12. While IDN-1 has many organizations focused on care integration, only 12 such organizations are at the core of the integration projects while the remaining are in supporting roles. IDN-1 has determined that it is appropriate to prioritize reporting of the Medicaid quality metrics to these core organizations that we think can have the largest impacts on the care of the Medicaid population. We will continue to hone this list once we receive detailed claims data from DHHS in April. This 'true up' of the metric target is also in alignment with what we think is operationally possible, though still a significant stretch.

Here is the list of organizations on which IDN-1 is focusing quality reporting deployment efforts:

1. *Alice Peck Day Primary Care*
2. *Cheshire Medical Center (DH Keene) - Primary Care*
3. *Dartmouth-Hitchcock Clinic Lebanon*
4. *Dartmouth-Hitchcock Psychiatric Associates*
5. *Monadnock Community Hospital - Primary Care*
6. *Monadnock Family Services*
7. *New London Medical Group Practice*
8. *New London Pediatric Care Center Practice*
9. *Newport Health Center Practice*

10. Valley Regional Hospital - Primary Care
11. Valley Family Physicians
12. West Central Behavioral Health

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

A2-6. IDN HIT: Budget

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

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

The Consultant costs cover the following:

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

The Software costs cover the following:

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

The following is a detailed HIT budget followed by the DHHS budget forms for each 6-month program period.

Figure 4: IDN-1 IT Solutions Budget

Redacted Table

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

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
specific details mandatory				
TOTAL	\$ 280,231.09	\$ -	\$ 280,231.09	

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

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

Organization Name	Organization Type
Alice Peck Day Memorial Hospital	Primary Care, Hospital
Crotched Mountain	Mental Health Provider
Dartmouth Hitchcock Keene	Primary Care, Hospital
Dartmouth-Hitchcock Clinic	Primary Care
Dartmouth-Hitchcock Psychiatric Associates	Mental Health Provider
Home Healthcare Hospice and Community Services	Home Health
Mary Hitchcock Memorial Hospital	Hospital
Monadnock Collaborative (Service Link)	Care Management
Monadnock Family Services	Community Mental Health Center
New Hampshire Hospital	Hospital
New London Hospital and Medical Group Practice	Hospital, Primary Care
New London Pediatric Care Center Practice	Primary Care
Newport Health Center Practice	Primary Care
Phoenix House	SUD Treatment
Planned Parenthood of Northern New England - Claremont	Primary Care
Planned Parenthood of Northern New England - Keene	Primary Care
Serenity Center	Community Support Provider
TLC Family Resource Center	Mental Health Provider
Valley Family Physicians	Primary Care
Valley Regional Hospital	Primary Care, Hospital
Visiting Nurse & Hospice of VT/NH	Home Health
West Central Behavioral Health	Community Mental Health Center

A2-8. IDN HIT. Data Agreement

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

Though not completed in the June – December 2017 reporting period, IDN-1 has been aggressively executing Data Sharing Agreements with Partner organizations in Q1 of 2018. We underestimated the complexity of this task including the substantial amount of new legal work that was required to chart a path for sharing federally protected part 2 information for purposes of quality reporting. In Q1 2018 we have worked through the major hurdles of data sharing with help from DHHS, UNH Law, IDN-1 legal counsel, IDN-1 Partner privacy officers, and the quality data vendor. This has resulted in a standard IDN-1

data sharing agreement that covers IDN-1, its partners, and its quality data services vendor to lawfully perform NH 1115 audit and evaluation functions.

The 6 IDN-1 organizations that submitted quality information to DHHS for the June – December 2017 reporting period (due April 1, 2018) all had proper data sharing agreements in place prior to data submission. IDN-1 is working with remaining IDN-1 Partners to execute any remaining agreements and to update older data sharing agreements to accommodate new changes to the part 2 rules.

The Project Plan section of this report has been updated to more specifically plan and track the execution of Data Sharing Agreements as part of Workstream 4.

Organization Name	Data Sharing Agreement Signed Y/N
Alice Peck Day Primary Care	Y
Child and Family Services	N
Crotched Mountain Community Care	N
Dartmouth-Hitchcock Clinic Lebanon	Y
Dartmouth Hitchcock Keene (Cheshire Medical Center)	Y
Dartmouth-Hitchcock Psychiatric Associates	Y
MAPS	N
Mindful Balance Therapy Center PLLC	N
Monadnock Community Hospital - Primary Care	N
Monadnock Family Services	Y
New London Medical Group Practice	Y
New London Pediatric Care Center Practice	Y
Newport Health Center Practice	Y
Phoenix House	N
Planned Parenthood of Northern New England - Claremont	N
Planned Parenthood of Northern New England - Keene	N
Southwestern Community Services	N
TLC Family Resource Center	N
Valley Family Physicians	Y

Organization Name	Data Sharing Agreement Signed Y/N
Valley Regional Hospital - Primary Care	Y
West Central Behavioral Health	Y

A2-9. Project Scoring: IDN HIT Process Milestones

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

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

Project B1: Integrated Healthcare

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

See B1-2a for the Implementation Timeline

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

Using Microsoft Project or similar platform, provide a detailed narrative which describes the progress made that includes a timeline of milestones and targets for each of the Process Milestone requirements listed for reporting periods of Jan-June 2017; July-Dec 2017; Jan-June 2018; and July-Dec 2018. See the DSRIP STCs and the IDN Integrated Healthcare Coordinated Care Practice and Integrated Care Practice milestones for additional detail.

Include a detailed narrative to complement the project plan or provide further explanation.

The Coordinated Care Practice must include:

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

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

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

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

B1 RFP and Implementation Waves

Overview of the IDN1 Process:

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

The RFA process in use has been endorsed as the strategy with the greatest likelihood of creating lasting change in the IDN and the most fiscally responsible strategy. The RFA processes and structures were

reviewed and endorsed by the Executive Committee. Wave I incorporated 3 rounds of the RFA process. Wave II launched in January of 2018 and will commence 3 rounds of the RFP at 1 month intervals. IDN1 has made no changes or alterations to the RFP forms and frameworks since they were established and reported on in the previous reporting period.

B1 DH/WCBH Integrated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care)

Current State: As of 12/31/17 the DH/WCBH project team had hired the CTC coordinator and finalized their preparation for onboarding and training in the first two weeks of January. In preparation for the CTC hire the combined team had mapped all project workflows for the DH and WCBH side, and prepared for go live of the Shared Care Plan. The Team will go live with patients in the 2nd week of January. A timeline of the semi-annual period activities is shared below:

- The DH/WCBH B1 Team began meeting in early July and will continue to meet with the IDN, QI coaches as well as participate in the B1 IDN-1 Knowledge Exchanges. This alignment of providers will bring members of DH Primary Care Heater Rd, DH Psychiatry, West Central Behavioral Health, IDN Region 1, and Citizen’s Health Initiative to the table biweekly to discuss next steps in implementation of the MDCT
- Creation of an Integrated Team charter

Example of the charter below:

1. General Project Information				
Project Name:	Behavioral Health and Primary Care Integration (Region 1, B1 BHI)			
Executive Sponsor:	Region 1 Executive Committee			
2. Project Team				
	Name	Organization or Department Affiliation	Telephone	E-mail
Project Leads:	██████████ ██████████	DH Primary Care Heater Road	██████████	██████████ ██████████
Data Lead:	██████████	DH Primary Care – Heater Road CTC		
Pratice Facilitator	██████████	IHPP/UNH	██████████	██████████
2 nd Prac. Fac	██████████	IHPP/UNH	██████████	██████████
West Central BH Lead	██████████	West Central	██████████	██████████
Team Member	██████████	West Central	██████████	██████████
Team Member	██████████	DH Primary Care	██████████	██████████

Team Member	[REDACTED]	DH Psychiatry	[REDACTED]	[REDACTED]
Team Member	[REDACTED]	Region 1/IDN	[REDACTED]	[REDACTED]
Team Member	[REDACTED]	West Central	[REDACTED]	[REDACTED]
IDN Data Lead	[REDACTED]	Region 1/IDN	[REDACTED]	[REDACTED]
IDN PM Lead	[REDACTED]	Region 1/IDN	[REDACTED]	[REDACTED]
IDN MD Lead	[REDACTED]	Region 1/IDN	[REDACTED]	[REDACTED]
IDN Lead	[REDACTED]	Region 1/IDN	[REDACTED]	[REDACTED]
Patient/Family Representative				

3. Stakeholders (e.g., those with a significant interest in or who will be significantly affected by this project)

Region 1 IDN, DH- Privacy/Security, DH-Legal, DH-Primary Care, DH-Psych., DH-Emergency Dept. West Central Behavioral Health, Population Health/Community Health Workers (CHW) Initiative, AmeriCorps CMHW, Primary Care Council, Heater Road Management Team, SUMHI, SDoH Workgroup

Community Partners: Twin Pines Housing Trust, Child and Family Services, NAMI, Tri-Community Action Program (CAP), Lebanon City Human Services Dept., DHHS, Servicelink, NH Voc. Rehab., Headrest, WISE of the Upper Valley, NH Legal Service, Grafton County Mental Health Court, Stagecoach (Medicaid Transport), Listen Community Services, AA/NA, Habit OPCO, Groups Recover Together, Road to a Better Life, The Haven

4. Project Scope Statement

Project Purpose Describe the need this project addresses

West Central Behavioral Health and DHMC are the two largest providers of medical and mental health services in our area. Many patients receive services provided by both organizations. Currently there is no clear process for ensuring the safe and optimal transfer of information or coordination of vital services for patients between the two organizations. This lack of coordination increases the risk of patients not receiving needed services, dropping out of treatment, or receiving costly duplicative treatment or suboptimal coordination of services.

The co-creation and ongoing mutual support of an inter-organizational multi-disciplinary team (MDT) led by a Medicaid Care Team Coordination (CTC) will help to bridge this gap to improve the delivery of care to patients, improve patient and provider satisfaction in delivering this care and improve the utilization of the valuable resources of each organization and their community partners.

Objectives <i>Describe the measurable outcomes of the project (e.g., reduce cost by xx, increase screening rates by yy)</i>
<ul style="list-style-type: none"> ● Improve the coordination of inter-organizational, patient-centered care for Medicaid patients. ● Improve health outcomes for Medicaid patients. ● Improve patient access to appropriate services matched to patient needs and delivered in an appropriate timeframe. ● Improve the use of existing resources. ● Improve both patient and provider satisfaction in delivering coordinated care between the two provider organization. ● Gather relevant data to ensure process and outcomes measures are being met. ● Work to ensure that the new team and process are sustainable and scalable.
Deliverables <i>List the high-level “products” to be created (e.g. process workflow created, shared care plan developed)</i>
<p>See implementation plan for more details.</p> <ul style="list-style-type: none"> ● Shared vision ● Process workflows ● Brief, patient centered education materials to introduce patients to the team structure, function and purpose ● Hire Care Team Coordinator (CTC) ● Shared care plan ● Comprehensive Core Standard Assessment (CCSA) ● Multi-disciplinary Core Team (MDT) ● Protocols for care transitions ● Intake procedure to solicit consent to share information
Scope <i>List what the project will and will not address (e.g. this project addresses all Medicaid patients, Medicare patients are not included)</i>
<p>Eligible Population:</p> <ol style="list-style-type: none"> 1) Medicaid beneficiaries ages ≥ 12 with identified behavioral health conditions who seek or receive care at WCBH Lebanon or DH Primary Care Heater Road Lebanon 2) Medicaid pts. with significant BH condition. “Significant”, for the purposes of this proposal is defined as “any Medicaid beneficiary who has a chronic mental health condition and/or has been recently hospitalized for medical or psychiatric care, evaluated in an emergency room for a mental health or substance use issue, or who through the behavioral health screening processes are judged to have ‘moderate to severe’ mental health or substance use symptoms or use.” <p>Heater Rd S1 Pilot Target:</p> <ol style="list-style-type: none"> 1. Medicaid member seen by S1 team providers, ≥ 12 to 64 years of age, with identified BH condition <ol style="list-style-type: none"> a. Secondary screen for existing relationship with West Central Behavioral Health or identified need for WCBH treatment. <ol style="list-style-type: none"> i. All other population eligibility requirements will be considered and honored but the priority pilot group will follow 1, 1a to narrow the initial implementation pool
Project Milestones <i>Propose start and end dates for Project Phases (e.g., Planning, Implementation) and other major milestones</i>
See milestones planning document

Measures & Outcomes *In this section list all objectives, measures, or outcomes including those listed in the AIM Statement.*

In addition to the standard data reporting required as part of the B1 Integrated Healthcare Project (see these measures on last page), this proposal will also be tracking and reporting on the following measures:

- Number of beneficiaries identified as being in need of monthly MDT review by the core team each month
- Number of ED visits by beneficiaries participating in monthly MDT reviews (and changes month to month)
- Number of inpatient medical admissions by beneficiaries participating in monthly MDT reviews (and changes month to month)
- Number of inpatient psychiatric admission by beneficiaries participating in monthly MDT reviews (and changes month to month)
- Monthly reporting on measurement based care outcomes for Depression, via the PHQ-9.

Major Known Risks *Identify obstacles that may cause the project to fail (e.g funding, time)*

Risk	Risk Rating (Hi, Med, Lo)
Information sharing, privacy, etc.	Hi
Funding Sustainability- Current tied to performance measurement and population outcomes Secondary- Need for addressing APM to support updating payment models for the MDCT	Hi
Time commitment	Med

Constraints *List any conditions that may limit the project team's options with respect to resources, personnel, or schedule (e.g., predetermined budget or project end date).*

Reimbursement for effective coordinated/integrated care.

Basic costs for starting and maintaining the program.

External Dependencies *Will project success depend on coordination of efforts between the project team and one or more other individuals or groups? Has everyone involved agreed to this interaction?*

CTC position hired

5. Communication Strategy *(specify how the project lead will communicate to the Executive Sponsor, Project Team members and other stakeholders, e.g., frequency of status reports, frequency of Project Team meetings, etc.)*

- The B1 Project team will meet bi-weekly in-person.
- The majority of monthly MDT meetings will be held via conference call with in person meetings at the beginning of the project and quarterly to help build a more cohesive sense of team and purpose and balancing the cost of more in person meetings.
- The core members of the MDT will then meet quarterly during the first year to review the program, successes, ongoing barriers to be problem-solved and data being collected.
- Regular email exchange about project updates
- Letter to stakeholders, more defined care planning mtgs, you may be invited to participate –Discovering same thing at WCBH as DHMC?

6. RELATIONSHIP TO OTHER PROJECTS *This section is to keep track of other projects related to this one. Are there projects that need to be completed in order for this project to reach completion? Do other projects need this project to be complete before they can start or finish?*

Project	Relationship Description	General Timeframe	Current Status
SUMHI			
SDoH Workgroup			

7. Sign-off

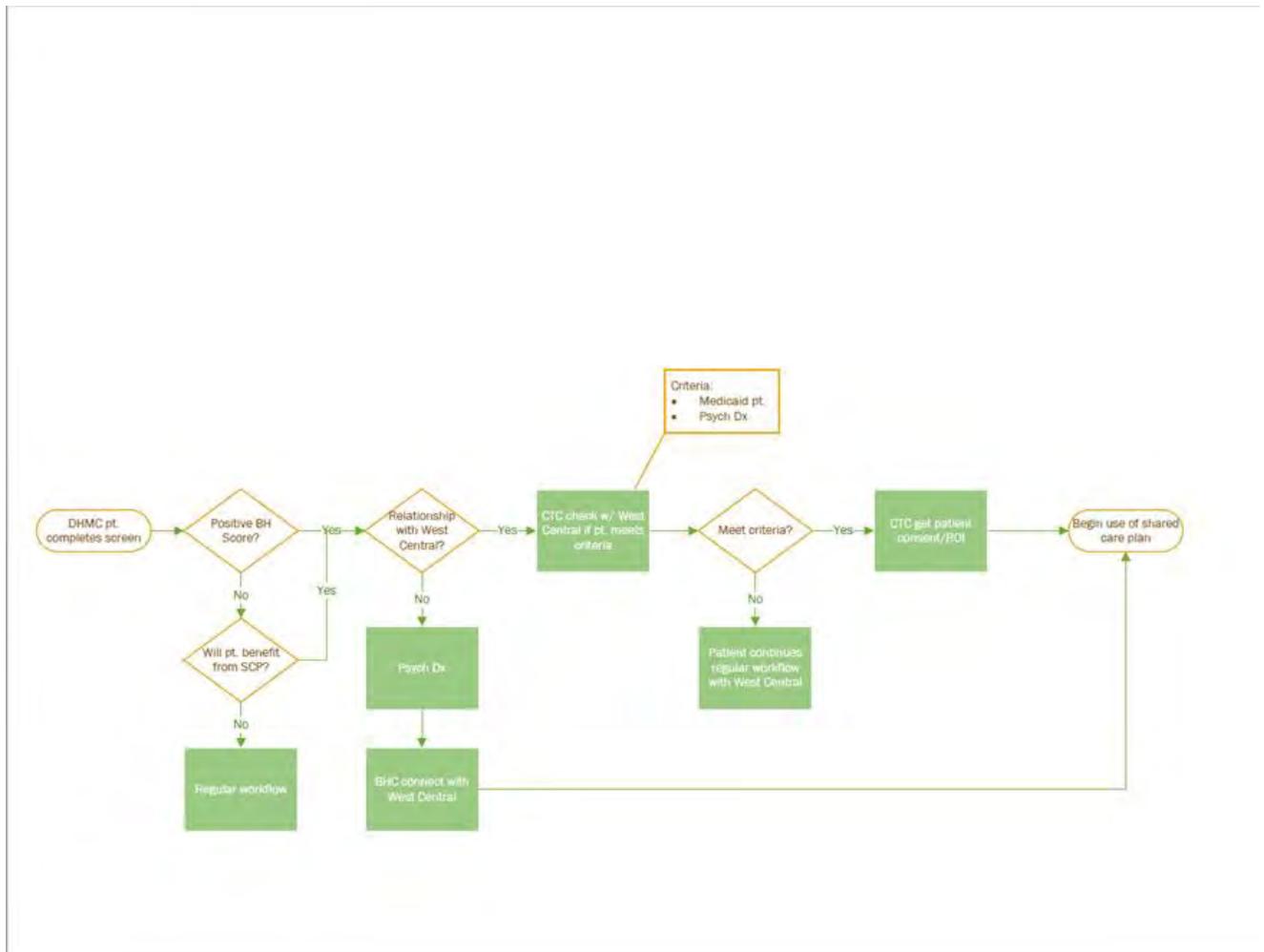
	Name	Signature	Date (MM/DD/YYYY)
Executive Sponsor			
Project Lead			

8. Notes

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- This team has completed the following which will be used as a model for new on boarded B1 projects across the IDN partners
 - Patient Assessment Process Mapping
 - SDoH Workflow
 - Charter Development
 - WCBH Workflow Process Mapping

Examples of the updated workflows shared below:



- The pilot in the B1 Wave 1 (B1W1) phase at DH/WCBH formalized their project team membership including identifying a physician champion and a community stakeholder liaison lead as well as a broad network of community service agencies that will support the MDCT patient pool. The network of support agencies covers all domains of the SDoH assessment targets as well as additional services
- B1W1 DH/WCBH team began ongoing meetings with the QI facilitator from CHI- as provided through the IDN-1 contract with CHI
 - Facilitated meetings allow for a % of contract weekly time to support the QI steps to ensure project success and flexibility to support team meetings at the frequency required for smooth implementation
- The SDoH workgroup that the IDN-1 team supports convened many times in Q3, Q4 and formalized a pilot launch of the questionnaire to get under way with the B1 W1 pilot team at Heater Rd. Clinic on Sept. 25th. This launch went well and the PDSA was restarted by early

October to account for question revisions and data pull clarity to ensure all MCO accounted. This workgroup bands together many separate projects and organization partners.

- Data leads have been established at DH- Heater Rd and WCBH. These leads have coordinated with the B1 DH/WCBH project team to establish the data fields have procured preliminary data pulls to guide the team development of a formal patient registry
- The DH/WCBH team hired for their CTC coordinator in early December, 2017 and became fully staffed in early January, 2018. The team commenced their pilot with 2-4 patients in mid-January 2018.
- The DH/WCBH team sent outreach to all project partner organizations with a one pager to update on the changes within the Heater Rd. practice and to share the services available to patients.
 - Example of outreach communication to partner organizations:

Good afternoon partners,

On behalf of the Heater Rd. Primary Care practice I wanted to reach out and share some exciting new initiatives for New Hampshire Medicaid patients underway within our practice:

- *New social determinants of health screening available to patients with their pre-appointment paperwork assessing the following domains:*
 - *Housing*
 - *Financial Resource Strain*
 - *Education*
 - *Social Isolation*
 - *Transportation*
 - *Employment*
 - *Legal Issues*
 - *Interpersonal Safety*
 - *In the event of a positive screen and patient indicated interest, a Community Health Worker will work hand in hand with the identified patient to access community supports targeting their identified barriers*
- *New pilot project with a dedicated Care Team Coordinator to convene monthly care plan meetings on behalf of identified high acuity NH Medicaid patients with behavioral health staff from West Central Behavioral Health and DH Primary Care. This pilot will also include:*
 - *Patient and provider access to a shared care plan that is aimed to support better integration among the patients providers and in shared goal setting with the patient and their family*
 - *Strong coordination between primary care behavioral health services as well as community mental health center support*

Please feel free to reach out for any additional information or if you're interested in becoming more involved with the projects development.

- A formal Orientation Handbook was developed to support the newly hired CTC coordinator and will be used for all subsequent hires.
- The team is in the process of defining a formal patient registry – See Draft outline below:

- The registry will be held in secure SharePoint and used by the Medicaid Care Team Coordinator to track the providers servicing a patient, track the notes and dates of coordination meetings and manage the tasks related to the care plan created for each patient.

Fields:

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

Requirement	Functionality assessment	Required?	Table	Status
▪ Task Due Date			Task List	
▪ Task Status	Not Started		Task List	
	In Process			
	Complete			
▪ Notes	Free Text		Task List	

Expansion of B1 Projects:

- The IDN-1 Exec. Committee voted to approve a 2nd collaborative B1W1 project to pilot bi-directional integration housed at Monadnock Family Services (MFS) with support from Cheshire Medical Center Primary Care. This project will tackle bidirectional integration with embedded primary care services available at MFS for highest acuity patients and likely commencing in early summer, 2018.
- The IDN-1 Exec. Committee voted to approve a 3rd collaborative B1W1 project to pilot integration at Valley Regional Hospital in partnership with Counseling Associates. The project team kicked off meeting in November, 2017.

Overview of the Proposed CMC/MFS B1 Pilot:

Target Population: Medicaid beneficiaries ages 12 and older with behavioral health conditions particularly severe and persistent mental illness (SPMI) or severe emotional disturbance (SED), or at risk for such conditions, who also have the need for medical care.

Goal Statement: This project will transform the way health and wellbeing is supported for Medicaid beneficiaries and will: 1) reduce the burden of physical and mental illness for those clients ages 12 and older with behavior health conditions through the creation of an multidisciplinary team of professionals and peer supports using best-practice coordinated care interventions and 2) develop an effective and efficient model for co-locating a Health Home in a community mental health center to deliver integrated primary and behavioral health care services that will achieve the Quadruple Aim.

Project Objectives:

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

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

Objective 3: Assist individuals in the Health Home with acquiring skills for managing their chronic illnesses in ways that reduce unnecessary emergency care and inpatient hospitalization, to be accomplished by a

combination of lifestyle coaching, building self-management skills, greater peer supports, and coordination of primary care and behavioral health service delivery.

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

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

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

Needs Addressed: It is clear that mental, behavioral, and substance use conditions adversely affect the course and treatment of chronic illnesses such as diabetes, heart disease, and cancer. For instance, depression is linked to poor diabetic control, having diabetes doubles the risk of depression, and patients who are depressed and have diabetes are more likely to develop complications and have higher healthcare costs. It is also known that primary care providers without behavioral health supports tend to rely heavily on pharmaceutical rather than psychosocial interventions; this diminishes the overall health and well-being of those with co-occurring behavioral health needs and leads to over utilization of the most expensive medical services (e.g., emergency departments). Persons with serious mental illness face numerous challenges to achieving and sustaining fitness and weight loss, including the metabolic effects of psychoactive medications, the impact of symptoms on motivation, poor diet, difficulty affording healthy foods, physical inactivity, and in-adequate access to safe, affordable, and supported options for physical exercise. Poverty, isolation, and other social or occupational deficits are more common in clients who have Medicaid.

Traditional primary care practices are often ill prepared and under staffed to treat behavior health problems, especially when a client's circumstances are compounded by the many social determinants that negatively affect health status. Like other community mental health centers in the nation, Monadnock Family Services (MFS) has focused almost exclusively on psychiatric disorders and not general health risks or conditions. We believe that community mental health center staff underestimates the chronic medical problems their clients face. All too common throughout the United States, this siloed approach to care, that underserves the healthcare challenges of clients who have both medical and behavioral health needs, is what our Health Home proposal intends to replace with a sustainable integrated model.

The Health Home proposed here also solves an important problem for about 12 adults with severe and persistent mental illness who, because of the behaviors engendered by their psychiatric disorders, can't access primary care services like other citizens. Psychiatric illness, especially when combined with substance abuse and poverty, can cause some adults to forget and/ or reject social norms that make having a primary care physician possible in our culture. Keeping appointment times and ineffective social skills, for example, can present barriers to receiving primary care.

Approach Overview: In 2014, CMC/DH and MFS began discussing ways to meet the whole health needs of those clients shared by both organizations. This proposed "reverse integration" demonstration project is one way for us to reach our goal of a fully-coordinated care system. Based on lessons learned in care delivery transformation and also in response to a nationwide shortage in primary care providers, CMC/DH

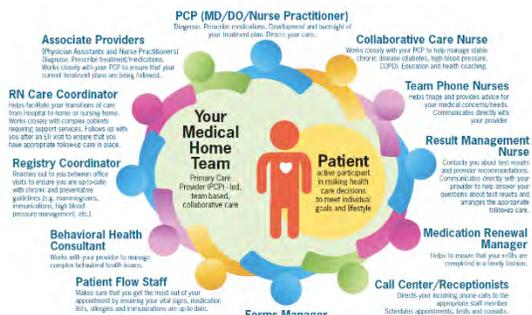
has evolved a next-generation Medical Home approach called the Collaborative Care Model (figure 1b). This team-based approach to care, which will now support the MFS Health Home (figure 1a), surrounds the patient with an array of care professionals to proactively recognize and meet care needs. Clients are seen as active participants in shared-decision making in all aspects of the chronic disease management.

Figure 1a:



MFS Health Home

Figure 1b:



CMC/DH Collaborative Care

MFS has long been concerned about how a community mental health center in New Hampshire can assist clients in their care with their primary health goals and challenges. Years ago, MFS pioneered a health improvement program called InSHAPE (see below) and have delivered smoking cessation interventions, diabetes prevention and education programs, and other health related services to their organization. According to a 2016 consumer satisfaction survey organized by the Bureau of Mental Health Services, MFS consumers expressed higher satisfaction than 8 of 10 community mental health centers when it came to six questions about their health and wellness, missing the top spot by one percentage point.

Based on the strengths of both organizational approaches to care and addressing the disconnection that has existed between our medical and mental health service delivery, we propose the co-location and integration of primary care and behavioral health services within the community mental health center. This combination of expertise and resources will bring the assets of both organizations into a synergistic, client-centered approach that will avoid duplication, reduce the likelihood of gaps in care, lower unnecessary acute care, improve outcomes, and lower cost. Participating Partners: The partner organizations will be Cheshire Medical Center/Dartmouth-Hitchcock and Monadnock Family Services. In addition, both organizations have longstanding relationships with area health and social service providers who will be engaged for the benefit of client needs.

Overview of the Awarded VRH/CA B1 Pilot:

Target Population: The Valley Regional Hospital (VRH) system provides community members with a Critical Access Hospital, three primary care outpatient centers and specialty practices in orthopedics, women’s health, oncology, urology, pulmonology, podiatry, cardiology and general surgery. With over 47,000 community members, residing across the 15 towns and 537 square-miles of Sullivan County, the rural landscape offers many challenges to accessing healthcare, be it oral, medical or behavioral health. Initially, the proposed VRH Behavioral Health Integration Project will focus on New Hampshire Medicaid patients, age 12 and over, receiving services within Valley Primary Care, referred to as VPC, herein.

However, as the pilot progresses, with success and best practices guiding the way, VRH will expand its initiative to all VRH primary practices and all patients, regardless of payment source.

Goal Statement: Over a three-year period, VRH will establish innovative and collaborative relationships with behavioral health providers and community partners; create effective and efficient procedures and workflows; and, shift traditional thinking to embrace a multi-faceted approach to mental health and primary care integration. Valley Primary Care will achieve Coordinated Care Practice Designation by December 2018.

Approach Overview: At the forefront of VRH's approach to pilot integration is a recognition of the electronic medical record system conversion currently underway. While this transition will conclude in May 2018, VRH is committed to building the foundation for integration and launching coordination steps following acceptance of the proposal. As stated by President and CEO Peter Wright in his letter of support, VRH's approach will focus on establishing work flows, relationships and procedures based upon national best practices in behavioral healthcare integration and telehealth, while simultaneously concluding the EMR system conversion. VRH staff will strategically coordinate the B1 stages of implementation during the EMR conversion in a way that promotes forward progress and maximizes positive patient experiences, while minimizing inefficiencies and interruptions in care. Year two will assess the successes and challenges of year one, with a goal to expand the pilot program throughout the entire patient population of Valley Primary Care, and all primary care practices within Valley Regional Hospital. Year three will identify and reinforce best practices of the previous two years, as we investigate a co-located behavioral health specialist or practice within Valley Regional's service space.

Project Objectives and Needs Addressed:

- I. Objective: Comprehensive Core Standardized Assessment Process
Need: Requirement for Coordinated Care Practice Designation
- II. Objective: Execution of a web-based Shared Care Plan
Need: Requirement for Coordinated Care Practice Designation
- III. Objective: Creation of a Multi-Disciplinary Team
Need: Requirement for Coordinated Care Practice Designation
- IV. Objective: Pilot an embedded tele psychiatry resource within the primary care setting to serve The identified patient population, as well as provide a resource for primary care physician consultation.
Need: The specific patients who will access the tele psychiatry module will be identified in additional conversations between VPC providers and the Department of Psychiatry.
- V. Objective: Establish (2) new FTE positions within Valley Primary Care – MSW and RN; establish a New Psych-APRN position for medication management (1) day per week.

Need: MSW will provide support to the patient in meeting care plan goals, providing support to core team members to ensure that the teams are coordinating care and communicating effectively, act in the role of social services navigator. RN will provide patient care coordination and triage and assist the MSW. The APRN will provide medication management assistance.

VI. Objective: Establish a bi-directional referral system with Counseling Associates of Claremont

Need: A revision to current patient assessment procedures will allow for increased opportunity to identify behavioral health issues, thus also providing opportunities to schedule appointments with Counseling Associates while the patient is at their primary care visit.

VII. Objective: Provide training opportunities to enhance support services for behavior health Integration at VPC, as well as partner development.

Need: Staff education and training are critical to the success of a behavioral health integration pilot. Once the core team has been identified for fit, attitude, and competency, initial training will be necessary, followed by consistent and ongoing professional development. The B1 initiative requires continual improvement and modification in program development, and it should have the flexibility and foresight to adjust itself as best practices evolve, while providing a consistent level of patient delivery.

Participating Partners:

Collaborative Partners

Counseling Associates of Claremont
Dartmouth-Hitchcock Medical Center, Department of Psychiatry

Stakeholder Partners

ServiceLink
Lake Sunapee VNA (LSVNA)
Planned Parenthood of New England (PPNE)
TLC Family Resource Center (TLC)

IDN1 B1 Partner Organizations

Given updated guidance made available to the IDN1 leadership team from DHHS changes have been made to the B1 organization cohort listing to maximize the impact on the IDN1 Medicaid population. As a number of the initially listed partner organizations have a very low attributed population (> 100 individuals) the IDN leadership team made the determination that focusing resources on the organizations with the highest proportion of covered lives would be the best stewardship of the available B1: Integrated Healthcare resources. The supplemental B1 partner's cohort will be included on the IDN1 B1 process but it is not anticipated that any of these partner organizations will directly lead or support a B1 project by 12/31/18 when the Coordinated Care Designation must be met.

For those organizations who have been removed from the ‘required’ cohort the IDN1 team hopes to involve these partners as support agencies for existing or soon to be implementing B1 project teams. IDN1 has taken a waved approach that allows for the slow rollout of practice site pilots and integration of multiple partners across Primary Care, Behavioral Health, and Community based services at each pilot site.

Updated IDN1 B1 Cohort:

Alice Peck Day Primary Care
Dartmouth Hitchcock Keene
Dartmouth-Hitchcock Clinic
Dartmouth-Hitchcock Psychiatry
Monadnock Hospital and Primary Care *Pending due to organizational commitment
Monadnock Family Services
New London Hospital and Medical Group Practice
New London Pediatric Care Center Practice
Newport Health Center Practice
Valley Family Physicians
Valley Regional Hospital
West Central Behavioral Health

Supplemental B1 Partners

Child and Family Services
Crotched Mountain Community Care
Headrest
MAPS
Mindful Balance Therapy Center
Phoenix House
Planned Parenthood of Northern New England - Claremont
Planned Parenthood of Northern New England - Keene
Southwestern Community Services
tlc Family Resource

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Organizations Assessing Medicaid Members with the CCSA	21	1		
# Organizations Contributing to and/or accessing Shared Care Plan	21	1		
# Organizations Initiating Referrals to Supports	21	1		
# Organizations Receiving Referrals to Supports	10	2		
# of Organizations meeting requirements of “Coordinated Care Practice”	21	0		
# of Organizations meeting requirements of “Integrated Care Practice”	4	0		

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.

Due to current level of implementation all staffing fields coded in orange are still pending waved organizational rollout of the project. IDN1 Administrative staff and leadership are still in ongoing conversations with many partners as to readiness for B1 implementation. One major factor affecting this readiness is the high level of available primary care and support positions at many partner sites. With lean teams and recurring vacancies the internal capacity of many partner agencies is severely limited. While there is organizational support of the IDN, there have been ongoing challenges in securing physician and clinical champions for B1 implementation. Additionally, many of the IDN1 B1 partners are working on expanded MAT capacity within their organizations and the topic of MAT capacity is recurring at many IDN workforce and project tables. In regard to staffing as the B1 projects expand from their initial implementation we anticipate seeing direct hiring and staffing allocation to be targeted specifically to MAT. More information will be provided in upcoming reporting periods.

Please note: “Pending Removal Due to Low Level of Attributed Medicaid Members” speaks to IDN1 organizations initially attributed to the B1 provider pool who do not have a significant level (less than 100) Medicaid patients seen annually. Given this the IDN1 team is working with the organizations to move them into support roles for pre-existing B1 projects.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Dartmouth Hitchcock Clinic -Lebanon	1	1	1		
Dartmouth Hitchcock Psychiatry					
West Central Behavioral Health					
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care	1	0	0		
Monadnock Family Services	1	0	0		
Alice Peck Day Primary Care	1	0	0		
Monadnock Hospital and Primary Care	Pending Removal Due to Limited Organizational Capacity				
New London Hospital and Medical Group Practice	1	0	0		
New London Pediatric Care	1	0	0		
Newport Health Center Practice	1	0	0		
Valley Family Physicians	1	0	Recruit to Hire		
Valley Regional Hospital	1	0	Recruit to Hire		
Child and Family Services	Pending Removal Due to Low Level of Attributed Medicaid Members				
Southwestern Community Services	Pending Removal Due to Low Level of Attributed Medicaid Members				
Crotched Mountain Community Care	Pending Removal Due to Low Level of Attributed Medicaid Members				
MAPS	Pending Removal Due to Low Level of Attributed Medicaid Members				
Mindful Balance Therapy Center	Pending Removal Due to Low Level of Attributed Medicaid Members				
Phoenix House	Pending Removal Due to Low Level of Attributed Medicaid Members				
TLC Family Resource Center	Pending Removal Due to Low Level of Attributed Medicaid Members				

B1-5. IDN Integrated Healthcare: Budget

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

The WCBH/DH B1 team officially hired their CTC in January 2018 and have made no changes to the budget fields reported below.

Given the start date of the CTC hire there has only been limited expenditures by the B1 team between July 1 and December 31, 2017, the WCBH/DH team expensed \$1801 towards its budget for salaries. This is reflective of staff time to support project planning meetings. A full project actuals budget will be available for the January-June, 2018 reporting SAR.

Please see the PPI section for an IDN overview budget for B1.

Organization Name:	D-H/WCBH						
Project Title:	Integration						
Start and End Date:	7/1/2017 to 9/1/2020						
Budget							
		Year 1		Year 2	Year 3	Totals	
	Start Date	7/1/2017-11/30/17	ACTUALS 7/1/17-12/31/17	12/1/17-05/31/2018	7/1/2018	7/1/2019	
Direct Expenses							
<i>Training/ Workforce Development</i>		\$2,500.00		\$2,500.00			
<i>Technology (Pager, Laptop, etc.)</i>		\$1,500.00	\$1,000.00	\$1,500.00			
<i>Recurring Expenses</i>		\$3,825.00		\$3,825.00			
<i>One-Time Expenses</i>		\$500.00					
Total		\$64,817.00		\$64,317.00	\$0.00	\$0.00	\$129,134.00
				*Not Finalized - Only a 6 Month Award was approved			
Indirect Expenses							
Billable							

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

(At the practice or independent practitioner level during this reporting period)

Organization/Provider	Agreement Executed (Y/N)
Dartmouth Hitchcock Primary Care- Lebanon	
<i>Heater Road S1 Team Practice</i>	Y
Dartmouth Hitchcock Psychiatry - All Organization	Y
West Central Behavioral Health - All Organization	Y
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care	Y
Monadnock Family Services	Y
Alice Peck Day Primary Care	Y
New London Hospital and Medical Group Practice	Y
New London Pediatric Care	Y
Newport Health Center Practice	Y
Valley Family Physicians	Y
Valley Regional Hospital	Y

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

IDN1 administrative team leaders have been in ongoing conversation with the leadership of the B1 partner agencies and those listed below are committed to participation and implementation of the B1 project.

Name	Title	Organization	Sign Off Received (Y/N)
Chelsea Worthen	Practice Manager at Heater Road	Dartmouth Hitchcock Clinic -Lebanon	Y
Dr. Will Torrey	Head of Psychiatry	Dartmouth Hitchcock Psychiatry	Y
Suellen Griffin	CEO	West Central Behavioral Health	Y
Dr. Andy Tremblay	Director of Primary Care	Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care	Y
Phil Wyzik	CEO	Monadnock Family Services	Y
Kristen Kniesel	Practice Manager	Alice Peck Day Primary Care	Y
Sally Patton, RN	Chief Nursing Officer	New London Hospital and Medical Group Practice	Y
		New London Pediatric Care	Y
		Newport Health Center Practice	Y
Angela Biron	Director of Physician Practices	Valley Family Physicians	Y
		Valley Regional Hospital	Y

B1-8. Additional Documentation as Requested in B1-8a-8h of the Project Scoring Tool in B1-9

*See next page for tables

B1-8a. CSA Utilization

IDN1 has established a gold standard for the CSA screenings throughout the Region. An SDoH screening bundle currently being piloted at the Heater Rd. B1 team is being made available to the IDN1 partner agencies. The second component of the CSA is the BH bundle that encompasses the Depression and SUD screenings which is rolling out in a separate implementation. These two components will be made available in the rollout of B1 projects. Given the unique nature of the B1 partners in IDN1 the decision had been made to allow for variability across the tools used for the CSA assessment. The IDN team in these instances will require documentation of the alternate tools being used and report on the data capture and notate the tools used.

The table below reflects utilization by organization as of 12/31/17. At the other B1 project team sites (CMC, MFS, VRH) the IDN team is supporting the rollout of the CSA process and building new clinical workflows around the process. The table below will be updated to include these sites once the CSA is being utilized in a screening capacity for patients.

CCSA Utilization Table																											
	Utilization July 1, 2017- December 31, 2017													Utilization January 1, 2018- June 30, 2018													
	Demographic Information	Physical Health Review	Substance Use Review	Housing Assessment	Family and Support Services	Educational Attainment	Employment or Entitlement	Access to Legal Services	Suicide Risk Assessment	Functional Status Assessment	Universal Screening: PHQ2,9	Universal screening: SBIRT	Demographic Information	Physical Health Review	Substance Use Review	Housing Assessment	Family and Support Services	Educational Attainment	Employment or Entitlement	Access to Legal Services	Suicide Risk Assessment	Functional Status Assessment	Universal Screening: PHQ2,9	Universal screening: SBIRT			
Providers																											
Alice Peck Day Primary Care	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
Dartmouth Hitchcock Keene	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
Dartmouth-Hitchcock Clinic	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y			
Dartmouth-Hitchcock Psychiatric Associates	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	Y	Y			
Monadnock Family Services	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
Newport Health Center Practice	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
New London Hospital and Medical Group Practice	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
Newport Health Center Practice	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
Valley Family Physicians	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
Valley Regional Hospital	Anticipated utilization after launch- projected not later than May 2018													Anticipated utilization after launch- projected not later than May 2018													
West Central Behavioral Health	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y			

B1-8a. Pediatric CSA Utilization

Given the phased rollout of the B1 partners in IDN1 the inclusion of the Pediatric CSA is moving secondary to the Adult CSA. We anticipate that there will be additional workgroup meetings to address the Pediatric CSA fields across B1 partners in the semi-annual term January-June, 2018.

	Utilization July 1, 2017-December 31, 2017		Utilization January 1, 2018-June 30, 2018	
	Validated Universal Screening: ASQ:3, and /or ASQ SE at 9, 18, 24/30 month pediatric visits	Developmental Screening using bright futures or other American Academy of Pediatrics recognized development tools	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				
New London Pediatric Care Center Practice	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
Alice Peck Day Primary Care	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
Dartmouth Hitchcock Keene	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
Dartmouth-Hitchcock Clinic	Y	Y	Y	Y
Dartmouth-Hitchcock Psychiatric Associates	Y	Y	Y	Y
Monadnock Family Services	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
New London Hospital and Medical Group Practice	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
Newport Health Center Practice	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
Valley Family Physicians	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
Valley Regional Hospital	Anticipated utilization after launch- projected not later than May 2018		Anticipated utilization after launch- projected not later than May 2018	
West Central Behavioral Helath	Y	Y	Y	Y

B1-8b. Multi-Disciplinary Core Team Members

All Organizations listed in blue are currently contracted with a B1 project. Those remaining organizations are expected to move forward with a B1 project during the upcoming two quarters of 2018.

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

B1-8c. Required Training

The IDN1 team supported by the Knowledge Map at DH have compiled trainings for the required fields detailed below. These trainings are shared with IDN1 partners in the monthly Knowledge Exchange sessions commencing in January, 2018. The IDN1 team chose to delay the start of trainings to build attendance momentum across IDN partners and to allow for initial sessions to focus on the pressing topics identified by attendants at the Fall Advisory Council.

Providers	Training Required									
	Diabetes Hyperglycemia		Dyslipidemia		Hypertension		Mental Health Topics (Multiple)		SUD Topics (Multiple)	
	PC Staff	BH Staff	PC Staff	BH Staff	PC Staff	BH Staff	PC Staff	BH Staff	PC Staff	BH Staff
Dartmouth Hitchcock Clinic -Lebanon, Dartmouth Hitchcock Psychiatric Associates, West Central Behavioral Health										
<i>Heater Rd Practice Team 1</i>	Attained	In Process	Attained	In Process	Attained	In Process	Attained	Attained	Attained	In Process
<i>Heater Rd Practice Team 2</i>	Attained	In Process	Attained	In Process	Attained	In Process	Attained	Attained	Attained	In Process
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services										
<i>Practice Team 1</i>	Attained	In Process	Attained	In Process	Attained	In Process	Attained	Attained	Attained	In Process
<i>Practice Team 2</i>	Attained	In Process	Attained	In Process	Attained	In Process	Attained	Attained	Attained	In Process
Alice Peck Day Primary Care	Completion not later than 5/31/18		5/31/18		5/31/18		5/31/18		5/31/18	
New London Hospital and Medical Group	Completion not later than 5/31/18		5/31/18		5/31/18		5/31/18		5/31/18	
New London Pediatric Care	Completion not later than 5/31/18		5/31/18		5/31/18		5/31/18		5/31/18	
Newport Health Center Practice	Completion not later than 5/31/18		5/31/18		5/31/18		5/31/18		5/31/18	
Valley Family Physicians, Valley Regional Hospital and Counseling Associates										
Practice Team 1	Completion not later than 5/31/18		5/31/18		5/31/18		5/31/18		5/31/18	

B1-8d.

The Region 1 IDN staff in partnership with the Executive Committee and Project teams have decided that the most valuable application of Mental Health training for non-direct care staff would be targeted at all Billing and Reception staff across B1 organizations. At minimum IDN-1 will support required trainings across both of these staff positions. Due to current project phase the exact number of staff at each provider site is not yet known. If there is demonstrated need for expansion of positions to be trained the IDN will support additional trainings. Also, in the instance an IDN partner requests training across other staff areas the IDN will support this request. The Region 1 team plans to cover domain areas aligned with Mental Health First Aid training in a high level 30-45-minute web based training that will be recorded and disseminated to all applicable staff throughout the wave implementation process. Also, the IDN1 team will leverage the resources shared by Region 2 for Mental Health First Aid training to be offered in spring of 2018 for continued training.

In the instance that a provider expresses interest in expanded training or additional information across any of the domain areas the Region 1 IDN team will facilitate the noted provider staff gain access to more robust training in the field area either online or in-person.

	Completion not later than 5/31/18		
	July 1, 2017- December 31, 2017	January 1, 2018-June 30, 2018	July 1, 2018- December 31, 2018
Providers			
Dartmouth Hitchcock Clinic -Lebanon, Dartmouth Hitchcock Psychiatric Associates, West Central Behavioral Health			
<i>Heater Rd Practice Team 1</i>	Training Completed	In Process	In Process
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services			
<i>Practice Team 1</i>	N/A	N/A	N/A
Valley Regional Hospital, Family Physicians, Counseling Associates			
<i>Practice Team 1</i>	N/A	N/A	N/A
Alice Peck Day Primary Care	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>
New London Hospital and Medical Group Practice	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>
New London Pediatric Care	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>
Newport Health Center Practice	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>	<i>Completion not later than 5/31/18</i>

B1-8e. Multi-Disciplinary Core Team Schedule

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

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

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

MDCT Monthly Schedule							
July 1, 2017- December 31, 2017		January 1, 2018-June 30, 2018			July 1, 2018- December 31, 2018		
Providers							
Dartmouth Hitchcock Clinic -Lebanon, Dartmouth Hitchcock Psychiatric Associates, West Central Behavioral Health							
<i>Heater Rd Practice Team 1</i>	Project Team Meeting 2nd, 4th Thursday of the Month	In Process			In Process		
Valley Regional Hospital, Family Physicians, and Counseling Associates							
Practice Team 1	Project Team Meeting 2nd, 4th Wednesday of the Month	In Process			In Process		
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services							
<i>Practice Team 1</i>	Not Applicable due to Project Launch Date						
Alice Peck Day Primary Care	Not Applicable due to Project Launch Date						
Hospital and Medical Group Practice	Not Applicable due to Project Launch Date						
New London Pediatric Care	Not Applicable due to Project Launch Date						
Newport Health Center Practice	Not Applicable due to Project Launch Date						

Throughout the July-December, 2017 term the planning team for the MDCT for the DH/WCBH pilot met bi-weekly in a steering capacity to prepare for project implementation and the rollout of the MDCT clinical interventions.

B1-8f. Secure Messaging

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

As of December 31, 2017 13 IDN-1 Core Partners were capable of exchanging Direct Secure Messages. This represents 62% of the overall target of 21 organizations connected to Direct Messaging. On the community side, 6 IDN-1 Supporting Partners were capable of exchanging Direct Secure Messages. This represents 67% of the overall target of 9 organizations

Note that IDN-1 remains flexible with regards to Direct Messaging. Our overarching goal is to support inter-organizational communication for purposes of improved care coordination. Direct Messaging is our preferred technology that can support this function at this time. Use of legacy communication channels (e.g., Fax, Mail) are not ideal but acceptable to the IDN as long as communication and coordination is improving. Use of emerging communication channels (e.g., Care Everywhere, CommonWell) are expected to eventually supplant Direct Messaging as the preferred standard for electronic communication and we look forward to helping our Partners evolve with improving technology.

B1-8g. Closed Loop Referrals

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

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

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

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

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

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

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

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

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

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

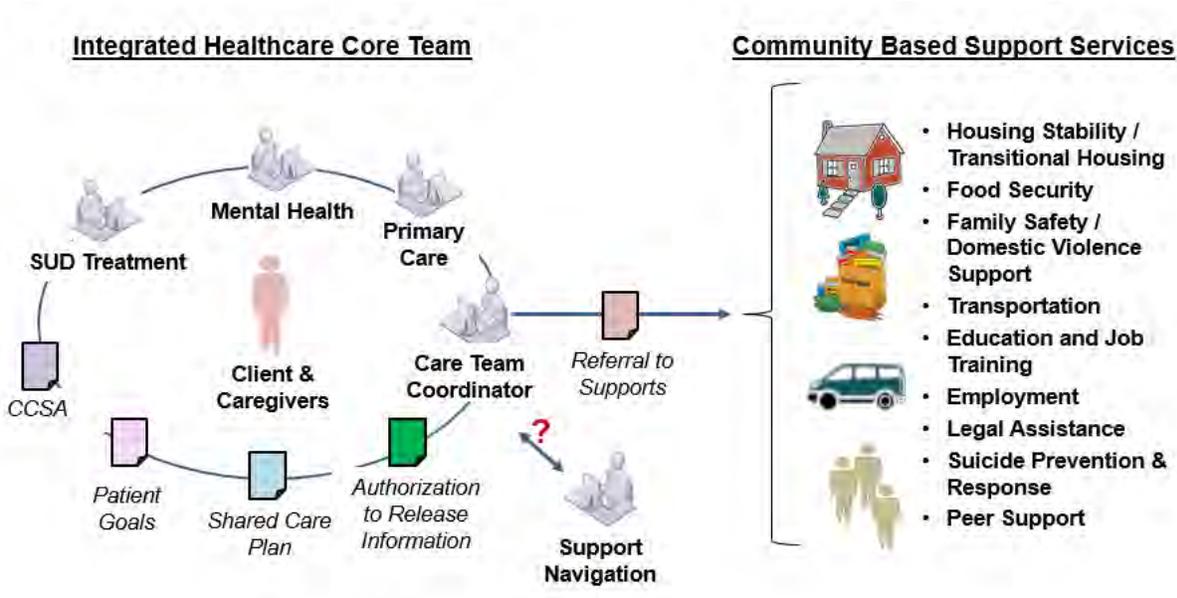
B1-8h. Documented Workflows and/or Protocols: No change from 7/31 Submission

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

Interactions between providers and community based organizations

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

Figure 12: Integrated Care Delivery Model



Population to be served:

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

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

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

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

The teams will focus on the high needs Medicaid Members as they transform care practice. Once new processes are established with this group they will be extended to the Medium Needs Members.

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

Support Team

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

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

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

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

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

Collaboration

The Integrated Delivery Team will follow the SAMHSA Six Levels of Collaboration framework and the corresponding definitions of Coordinated Care Practice and Integrated Care Practice from DHHS to guide intra-team communication. The organizations will baseline current level of collaboration with the Citizen's

Health Initiative assessment tool. With ongoing coaching from the CHI Team, the Integrated Care Team will improve collaboration and communication over the waiver period.

Figure 13: SAMHSA Six Levels of Integration

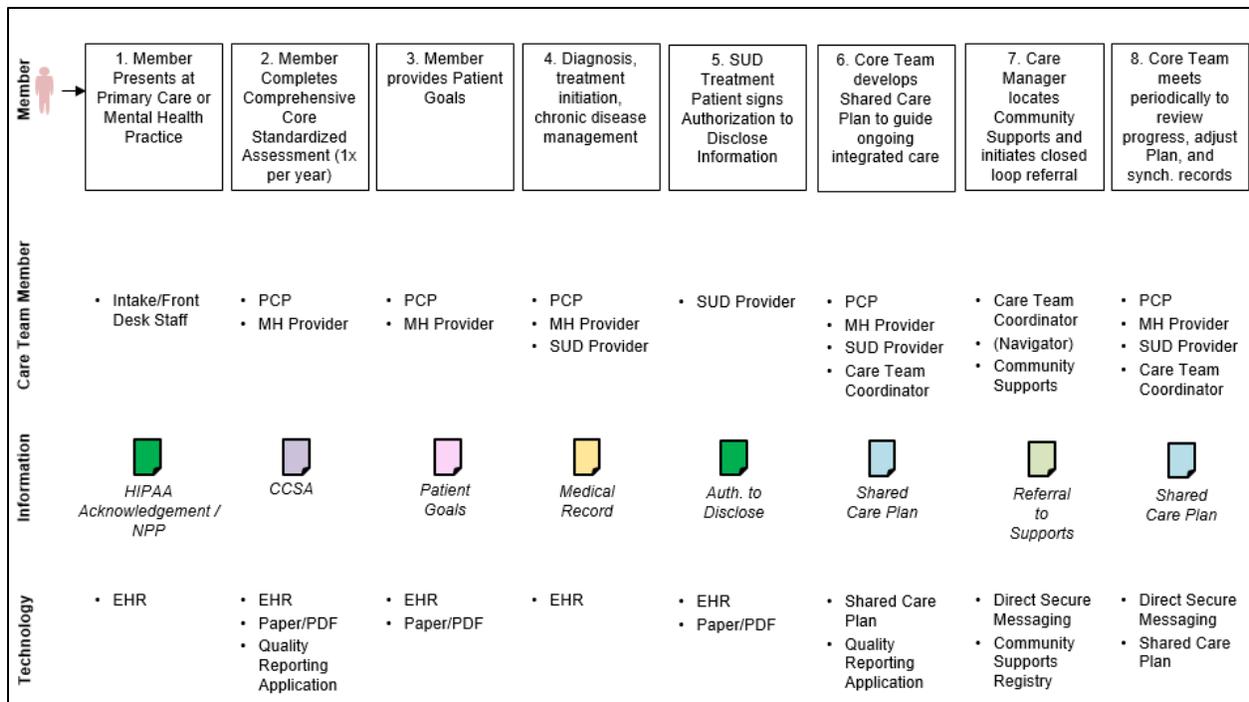
COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL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

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

Integrated Care Team Process Flow

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

Figure 14: Integrated Care Team Process Flow



Shared Care Plan

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

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

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

Timely communication

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

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 send.
For all referrals close the loop by Community Support Services Organization to confirm that Medicaid Member utilized services	Within 10 business days of message send.

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

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

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

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

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

Coordination among case managers (internal and external to IDN)

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

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

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

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

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

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

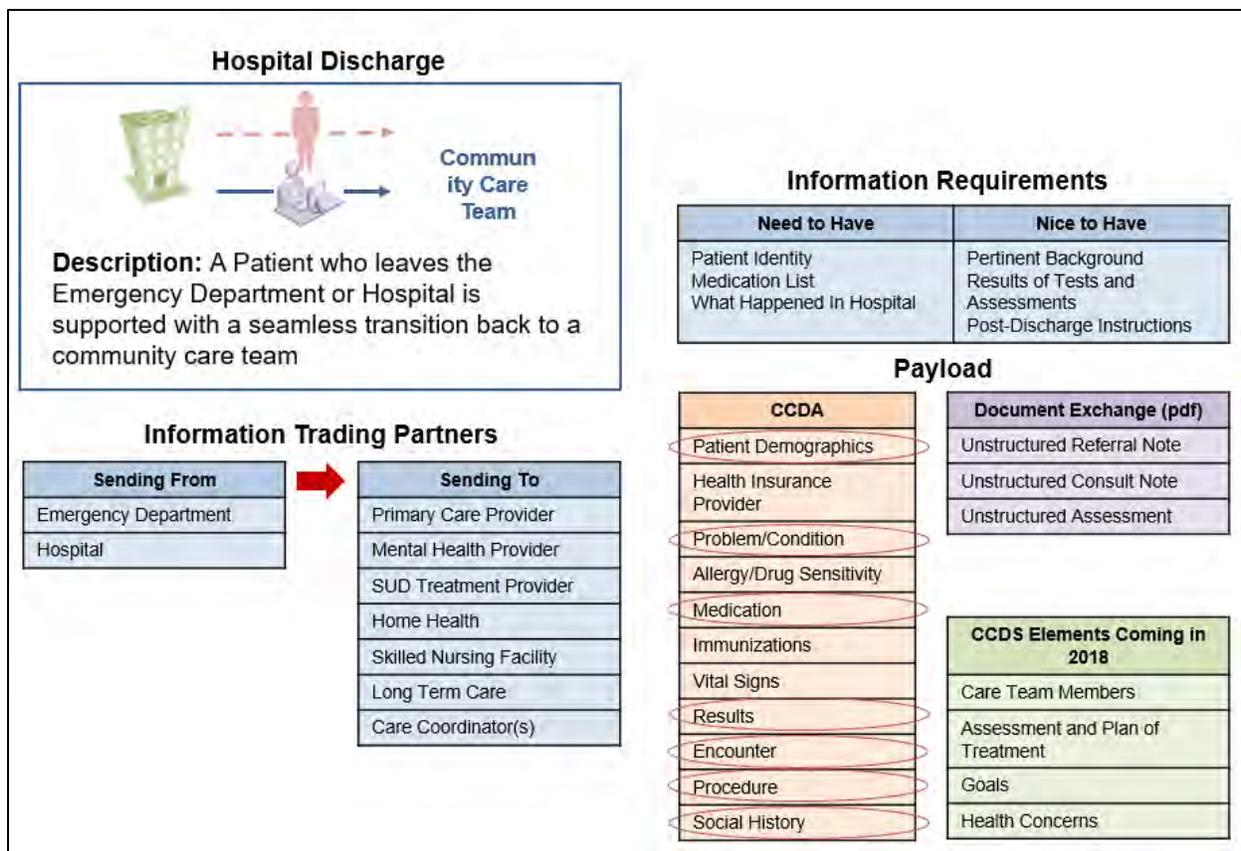
Current medication list – to enable medication reconciliation among all post-acute care providers and to prevent medication based adverse events.

Recent history of what happened during the hospitalization, any new problems discovered, any procedures undergone, and any new history discovered.

Instructions for who is to do what in a post-discharge hand-off between healthcare teams.

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

[Figure 15: Institutional/Hospital Discharge Workflows](#)



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

Adherence to NH Board of Medicine guidelines on opioid use:

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

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

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

- NH Board of Medicine Resources: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>

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

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

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

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

1. Complete SSA surveys by fall 2017 : *Completed*
2. Re-define B1 partner implementation waves as needed by 12/31/17: *Completed and Relaunching in March/April, 2018*
3. Engage partners in practice change initiatives starting in October, 2017: *Completed and recurring monthly*
 - Using Knowledge Exchange sessions to form a cohort of partners
4. Plan for secondary steps to achieve CC status at each practice within 4-6 months of starting its B1 pilot : *Ongoing*

Next Steps for January-June, 2018:

- 1 Continued implementation rollout across the IDN1 B1 partners
- 2 Ongoing Shared Care Planning and CSA Trainings/Work Sessions

*Please see B1: Appendix K for the SSA Reports from Region 1 B1 Partners

B1-9b.

MAT and evidence based treatment of mild to moderate depression is currently in practice at the DH Lebanon Heater Rd clinic. MAT protocols are being refined at time of submission. Initial education and MAT training materials can be found in Attachment_B1.9b.

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

- Cheshire Medical Center – Refining through expansion grant
- Alice Peck Day- Currently Implementing
- Phoenix House
- DH-Psych (PATP)

Through the ongoing analysis with B1 providers the IDN team will continue to assess new MAT capacity within providers and discuss readiness for implementation. Region 1 Medical Director has been working closely on the newly funded MAT initiative at Alice Peck Day Hospital. Continued coordination will look to align with the rollout of a B1 project at APD Primary Care.

Updated MAT Involvement in IDN1 July-December, 2017:

- The Region 1 Medical Director is participating is on the steering committee and participating in a statewide Community of Practice for MAT initiative spearheaded by BDAS, JSI and the Foundation for Healthy Communities.
- IDN1 is involved in development of Addiction 101 curriculum, which includes MAT, designed to be offered to primary care practices throughout NH
- Peter Mason, IDN1 Medical Director, is involved in the MAT program, to be implemented in the second week of April, at the Multispecialty Clinic at APDMH. This program also involves another Region 1 partner, Headrest, and is facilitated by the American Academy of Addiction Psychiatry, which is providing technical support. The program is designed as a model for overcoming the barriers to expanding MAT in primary care practices, and the lessons learned will be rolled out to other Region 1 primary care practices by December of 2018.
- IDN1 is beginning to coordinate with the ongoing MAT work at the GIM (General Internal Medicine) department at Mary Hitchcock Memorial Hospital.
- IDN1 is continuing to discuss MAT integration with all of the network partners and will coordinate wherever possible

B1-9c. HIT

Organization	Use of Technology to Identify at Risk Patients - May Include: -EHR System -Pre-Manage -Quality Data Center -MCO Data	Use of Technology to Plan Care - May include: -EHR System -Pre-Manage	Use of Technology to Monitor/manage patient progress toward goals - May include: -EHR System -Pre-Manage -Quality Data Center	Use of Technology to Ensure closed loop referral - May Include: -Direct Secure Messaging -CommonWell/Carequality -Other Referral Method
Alice Peck Day Primary Care	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Cheshire Medical Center - Primary Care	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Child and Family Services	EHR System: No Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: No Pre-Manage: No	EHR System: No Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Crotched Mountain Community Care	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Dartmouth-Hitchcock Clinic Lebanon	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Dartmouth-Hitchcock Psychiatric Associates	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
MAPS	EHR System: No Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: No Pre-Manage: No	EHR System: No Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Mindful Balance Therapy Center PLLC	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Monadnock Community Hospital - Primary Care	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Monadnock Family Services	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
New London Medical Group Practice	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
New London Pediatric Care Center Practice	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Newport Health Center Practice	EHR System: Yes Pre-Manage: No Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Phoenix House	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Planned Parenthood of Northern New England - Claremont	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Planned Parenthood of Northern New England - Keene	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Southwestern Community Services	EHR System: Yes Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
TLC Family Resource Center	EHR System: No Pre-Manage: No Quality Data Center: No MCO Data: No	EHR System: No Pre-Manage: No	EHR System: No Pre-Manage: No Quality Data Center: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
Valley Family Physicians	EHR System: No Pre-Manage: No Quality Data Center: Yes MCO Data: No	EHR System: No Pre-Manage: No	EHR System: No Pre-Manage: No Quality Data Center: Yes	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Valley Regional Hospital - Primary Care	EHR System: Yes Pre-Manage: No Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: No
West Central Behavioral Health	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: No
Key:				
Little or no IT capability to support the function.				
Some siloed (single organization) IT capability to support the function.				
Multi-organization IT capability in place to support the function.				

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

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

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

IDN-1 is utilizing Pre-Manage ED to identify patients that are frequent users of area Emergency Departments. Right now 3 of 6 hospitals are populating Pre-Manage ED with live encounter data while 2 hospitals are close to go live. ED use is a strong indicator that patients are at risk and/or have complex care needs.

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

IDN-1 Partners are being 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.

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

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

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

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

Care plans are informed by:

Patient medical records housed in the EHRs

Patient Goals – housed in the EHRs and Shared Care Plan

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

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

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

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

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

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

Use of Technology to Ensure closed loop referral: IDN-1 is planning to use Direct Secure Messaging as the primary technology for closed loop referrals. IDN-1 will remain open to other technologies that support closed loop referrals as they emerge.

B1-9d. Workflows: No change since 7/31/17 Reporting

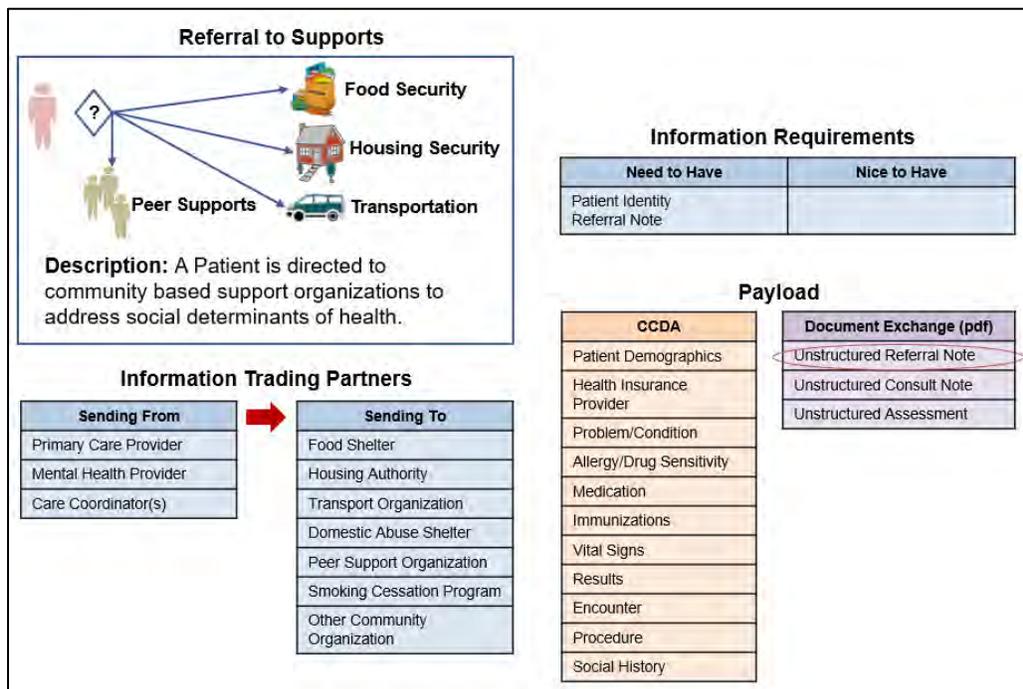
IDN-1 will support a formal bi-directional referral process when jointly serving patients with community based social support services organizations. There are two primary workflows:

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.

Updates as of 12/31/17: IDN1 is continuing to work with the B1 teams to develop their capacity for community support referrals and is anticipating updates for the next semi-annual report

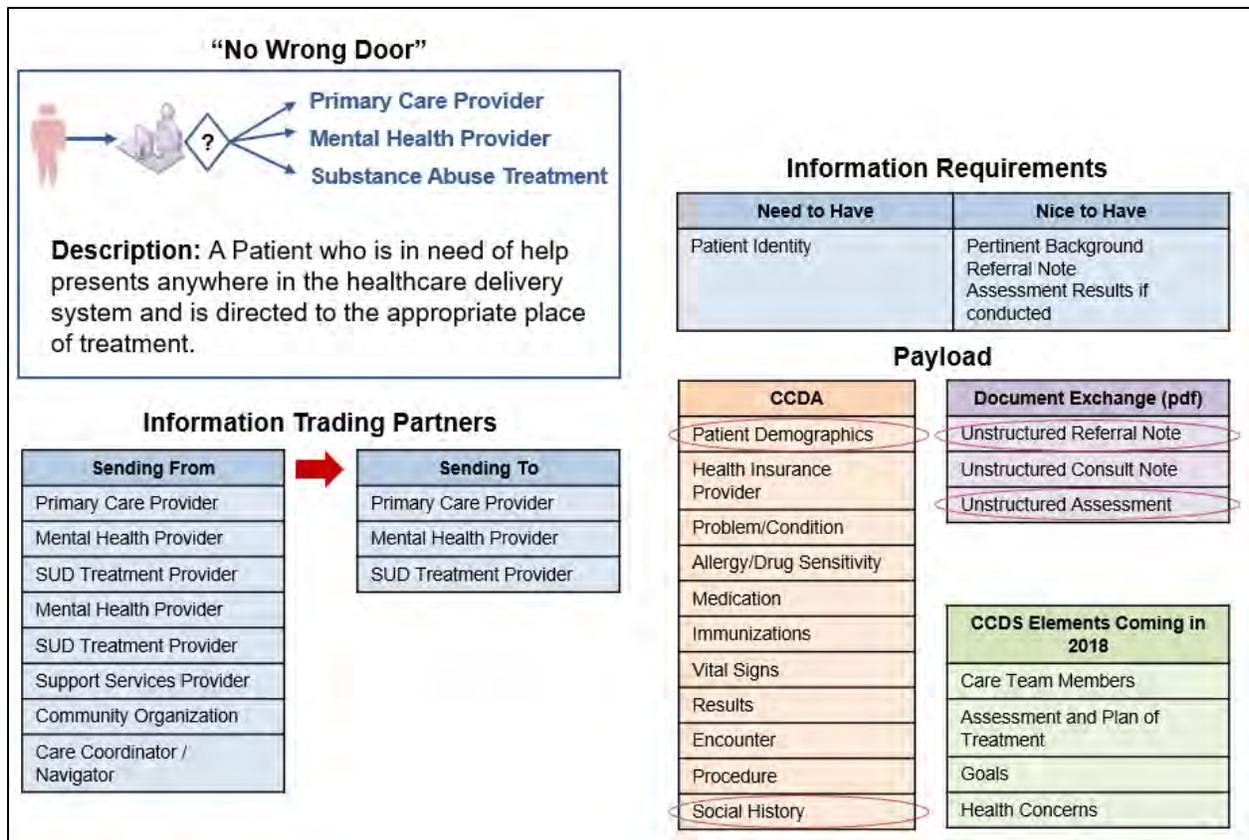
Figure 16: Referral to Supports Workflows



“No Wrong Door”

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

Figure 17: "No Wrong Door" Workflows



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

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

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

B1-9. Project Scoring: IDN Integrated Healthcare Process Milestones and Achievement of Coordinated Care Practice Designation Requirements

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-1	IDN Integrated Healthcare: Assessment and Ongoing Reporting of Current State of Practice Against SAMHSA Framework for Integrated Levels of Care and Gap Analysis	Narrative				
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: <ul style="list-style-type: none"> • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services 	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-8c	<p>Multi-disciplinary core team training for service providers on topics that includes, at minimum:</p> <ul style="list-style-type: none"> • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple) 	<p>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.</p> <p>OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress</p>				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		for each training				
B1-8d	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	<p>Documented work flows and/or protocols that include, at minimum:</p> <ul style="list-style-type: none"> • Interactions between providers and community based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to 	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
	primary care, behavioral health and social support service providers <ul style="list-style-type: none"> • Intake procedures that include systematically soliciting patient consent to confidentially share information among providers • Adherence to NH Board of Medicine guidelines on opioid prescribing 					

B1-10. Additional Documentation as Requested in B1-9a - 9d of the Project Scoring Table in B1-11 below.

B1-11. Project Scoring: IDN Integrated Healthcare Process Milestones, Achievement of *Integrated Care Practice* Designation Requirements

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

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		<ul style="list-style-type: none"> Joint service protocols Communication channels 					

B1-12. Project Scoring: 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.

	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	21	0	At minimum 1	At minimum 5	Up to 21
Integrated Care Practice	4	0	0	Up to 1	Up to 2

Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/2018	12/31/2018
	21	At minimum 1	At minimum 5	Up to 21

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/2017	6/30/2018	12/31/2018
	4	0	Up to 1	Up to 2

Please note that providers in the Coordinated Care Practice Designation cohort may shift as providers target further integration activities over the lifetime of the IDN implementation period. See the table below for Integrated and Coordinated Designation targets by IDN1 B1 providers:

Organization	Coordinated Care	Integrated Care
Alice Peck Day Primary Care	X	
D-H Keene	X	X
D-H Clinic Lebanon (Heater Rd, GIM)	X	X
D-H Psychiatry	X	X
Monadnock Hospital and Medical Group Practice	X	
Monadnock Family Services	X	X
New London Hospital and Medical Group Practice	X	
New London Pediatric Care Center Practice	X	
Newport Health Center Practice	X	
Valley Family Physicians	X	
Valley Regional Hospital	X	
West Central Behavioral Health	X	

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 attachment C-1a for the Implementation Timeline

IDNs were required to complete an IDN Community Project Implementation Plan including design and development of clinical services infrastructure plan for each selected community project. Using Microsoft Project or similar platform, provide a detailed narrative which describes progress made on the required activities, timelines, milestones, and progress assessment checkpoints for implementing the IDN's community project.

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

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

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

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

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. The project will combine implementation efforts for Enhanced Care Coordination and Care Transitions into one project that accomplishes all the goals of the ECC and CTI work in the Monadnock sub-region of the IDN. As a collaborative team they will build upon the successful partnership between CMC/DH and MC, the local Service Link Resource Center (SL), where a coordinated care transition for high acuity patients has been in operation for several years by 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 participants in carrying out their plan of care by

accessing the community services that are needed in addressing their multiple and complex needs. Though based at MFS, team members will be visible and active at the CMC/ DHK facility, communicating and consulting with the participants and their care providers in both the inpatient and outpatient service setting.

This team will seamlessly implement the (1) Critical Time Intervention (CTI) approach to provide care at staged levels of intensity to patients with serious mental illness during transitions from Cheshire Medical Center or New Hampshire Hospital to the community setting and (2) community based coordination and direct support services for recipients regarded as having complex health care needs: physical 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 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 that 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 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 for the targeted population. Particularly those who are transitioning to the community from in-patient settings and those with complex physical or mental health needs. The purpose of the Co-Pilot project is twofold: 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 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 and develop an effective workflow, development of referral process, implementation of the three phases of the CTI model, implementation of the enhanced care coordination model, consistent monitoring of metrics before, during, and after CTI services are provided and same for enhanced care coordination. The administrative oversight for implementation of this project rests with MFS. MFS will provide staffing supports to ensure administrative aspects of this project are completed.

Complex case coordination services 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 multidisciplinary core team assisting the individual in the primary care B1 Integration work. These services will extend coordination, 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 restrictions imposed by current regulations regarding the level of severity of mental health disability that individuals must pass 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 Coordinator positions, one of which 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 among other topics.

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.

The Region 1 IDN team is looking to scale the CTI model to other areas of the IDN1 catchment area in 2018 through support of a focused C1 RFP and support for IDN partners to participate in the Spring, 2018 CTI training offered by CACTI. Of note, while there is still a lack of clarity regarding continued funding at the statewide IDN level the Region 1 team is holding on all new RFP releases.

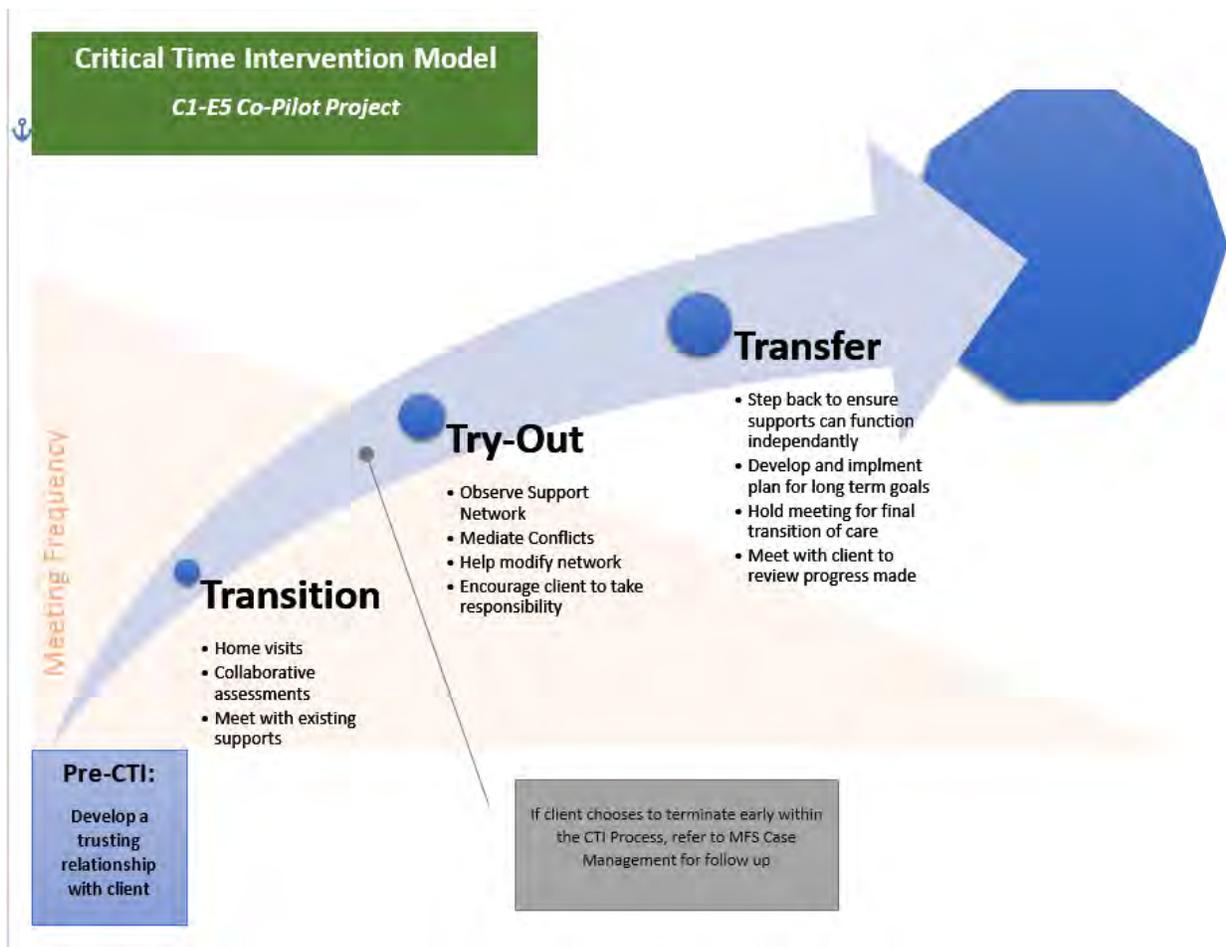
Updates for Co-Pilot July –December, 2017:

The Co-Pilot coordinated project supported by Monadnock Family Services, Monadnock Collaborative, and Cheshire Medical Center blends the project components of the C1: Care Transitions and E5: Enhanced Care Coordination projects. In the term of July-December 2017 the project team met weekly to work through patient flows and project referral and process development. Some primary objectives during this period of work have been:

- Recruit to Hire Activities for the 4 Co-Pilot coordinators
 - Two coordinators focused on the E5 ECC
 - Two coordinators focused on the C1 CTI
 - Team Lead Supervision
- Patient Referral Flow from CMC to the Co-Pilot Team
 - Built from the Care Transitions model currently co-located at Cheshire Medical Center ED
- Project Process Mapping
 - CTI Phase I-III
 - Enhanced Care Coordination Path
 - Referrals to MFS
- Determination of Criteria for Project Referral

- Defining key components for project streams
 - Criteria for referral to CTI
 - Criteria for referral to ECC
- Screening Tool Review
 - Revisit identified screening tools
 - Use comparative process to narrow down screening tools to 3 or fewer choices
- Data Tracking Review
 - Streamlined Referral Tracking
 - Alignment to Community of Practice and CTI standards for data
 - Alignment to IDN determined evaluation framework (See table in C-2)

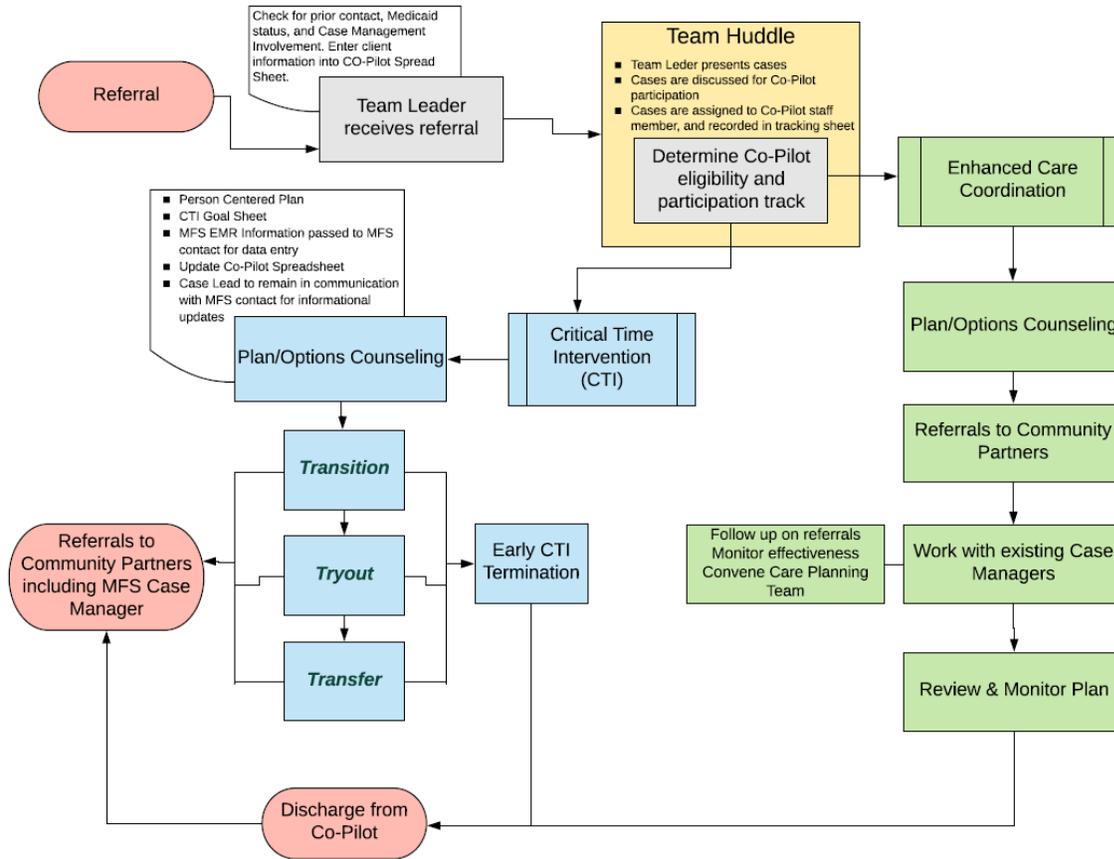
Please see below for the process maps created by the Co-Pilot team outlining the flow of the CTI program component, ECC program component, and overarching referral process for all project streams.



Enhanced Care Coordination Model
C1-E5 Co-Pilot Project



C1- E5 Co-Pilot High Level Project Process Map



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.

Due to the project rollout timeline the coordinated C1/E5 team has not yet begun to see patients during the reporting period July –December 2017. Formal program launch commenced with accepted referrals in mid- January 2018 as all 4 coordinator staff have been hired and the team processes are formalized. Despite the delay in clinical intervention the team has successfully stayed on track with milestones determined in their implementation plans.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Project Defined Patient Measures				
<i>Reduce the number of poor mental health days amongst adults from 3.8 in 2015 to 2.8 in 2019 (source: County Health Rankings)</i>	Will become effective post Q1, Q2 of Project Implementation due to program launch, training	Performance measure will begin tracking in next quarter		
Indicator 1: Decrease in client self-reported poor mental health days				
Indicator 2: Increase in number of social interactions per week				
Indicator 3: Increase in participation in any groups (social, religious, self-help, public service, etc)				
<i>Reduce overall homelessness in Cheshire county from 96 in 2016 to 86 (source: NHDHHS-County Level Information)</i>				
Indicator 1: Increase in number of people placed in housing				
Indicator 2: Increase in number of people working with housing services				
Indicator 3: Decrease in consecutive days without shelter				
<i>Reduce social isolation (source: GMPHN Community Survey)</i>				
Indicator 1: Increase the number of social engagements (i.e. church events, visits with neighbors/friends, attending community events)				
Indicator 2: Increase the number of referrals accepted for services and social resources in the community				
Indicator 3: Increase the number of individuals identified as members of their support network				
STC Defined Program Measures				
<i>All performance measures identified within the evaluation plan milestones</i>	100%	100%		
<i>Operationalization of Program</i>				
A. Implementation of Workforce Plan				
B. Deployment of Training Plan				
C. Implementation of any required updates to clinical protocols, or other operating policies and procedures				
D. Use of assessment, treatment, management and referral protocols	100%	100%		
<i>Initiation of Data Reporting</i>				
A. Number of individuals served vs. projected				
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected				
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	100%	100%		

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.

The project team has been fully hired since mid-fall 2017.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Transition Coordinator	2 FTE	0- In process to Recruit to hire	2 FTE		
Enhanced Care Coordinators	2 FTE	0- In process to Recruit to hire	2 FTE		
Supervisor	1 FTE	In process to reallocate Current Staff % FTE	1 FTE		

C-4. IDN Community Project: Budget

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

The Co-Pilot team has made no notable changes to the utilization of funds or budget categories as described in the table below.

Actual Expenditures July-December, 2017:

Monadnock Family Services

IDN Budget - Copilot

FY18

Expenses:	Budget	Nov	Dec
Salaries	77,000.00		3,566.26
Benefits	16,800.00		
Retirement	770.00		23.46
PR Taxes	7,700.00		179.50
Outside Contractors	107,061.00		
Training/Conferences	450.00		
Telephone	1,800.00		
Computer Related	3,000.00		2,022.93
Office Supplies	300.00		

Office Equipment	300.00			
Advertising	750.00			
Rent	2,400.00			
Travel Exp	3,600.00		3.15	
Client Services	1,000.00			
Insurance	475.00			
Admin	26,809.00		579.53	
Total	250,215.00	-	-	6,374.83

Organization Name:	MFS				
Project Title:	Co-Pilot				
Start and End Date:	7/1/2017 to 9/1/2020				
Budget					
	Year 1	Actuals 7/1-	Year 2	Year 3	Totals
<i>Start Date</i>	<i>7/1/2017</i>	<i>12/31/17</i>	<i>7/1/2018</i>	<i>7/1/2019</i>	
Direct Expenses					
<i>Fringe Benefits</i>	\$0.00	\$23.46	\$0.00	\$0.00	
<i>Training/ Workforce Development</i>	\$0.00		\$0.00	\$0.00	
<i>Technology (Pager, Laptop, etc.)</i>	\$6,600.00	\$2,022.93	\$6,600.00	\$6,600.00	
<i>Recurring Expenses</i>	\$7,800.00		\$7,800.00	\$7,800.00	
<i>One-Time Expenses</i>	\$2,800.00	\$579.53			
Total	\$219,363.00		\$216,563.00	\$216,563.00	\$652,489.00
Actuals Total		\$6,192.18			

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

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

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

Across the blended project team staff from Monadnock Family Services and Monadnock Collaborative work together through EHR access at Cheshire Medical center where patient identification for the project streams occurs. Dependent on the patient needs and support under CTI or ECC there is significant variance across the assessment tools used. Primarily, the team uses the CANS/ANSA tools as supported by MFS to look at social determinants and other risk factors for project team patients

Standard Assessment Tool Name	Brief Description
CANS/ANSA (CMHC Mandated Screener)	Childs Needs and Strenghts Assessment/ Adult Needs and Strenths Assessment
CTI Tracking Tool	CACTI Developed Patient Reporting Tool
Framed by CTI Model, Person Centered Planning	

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

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

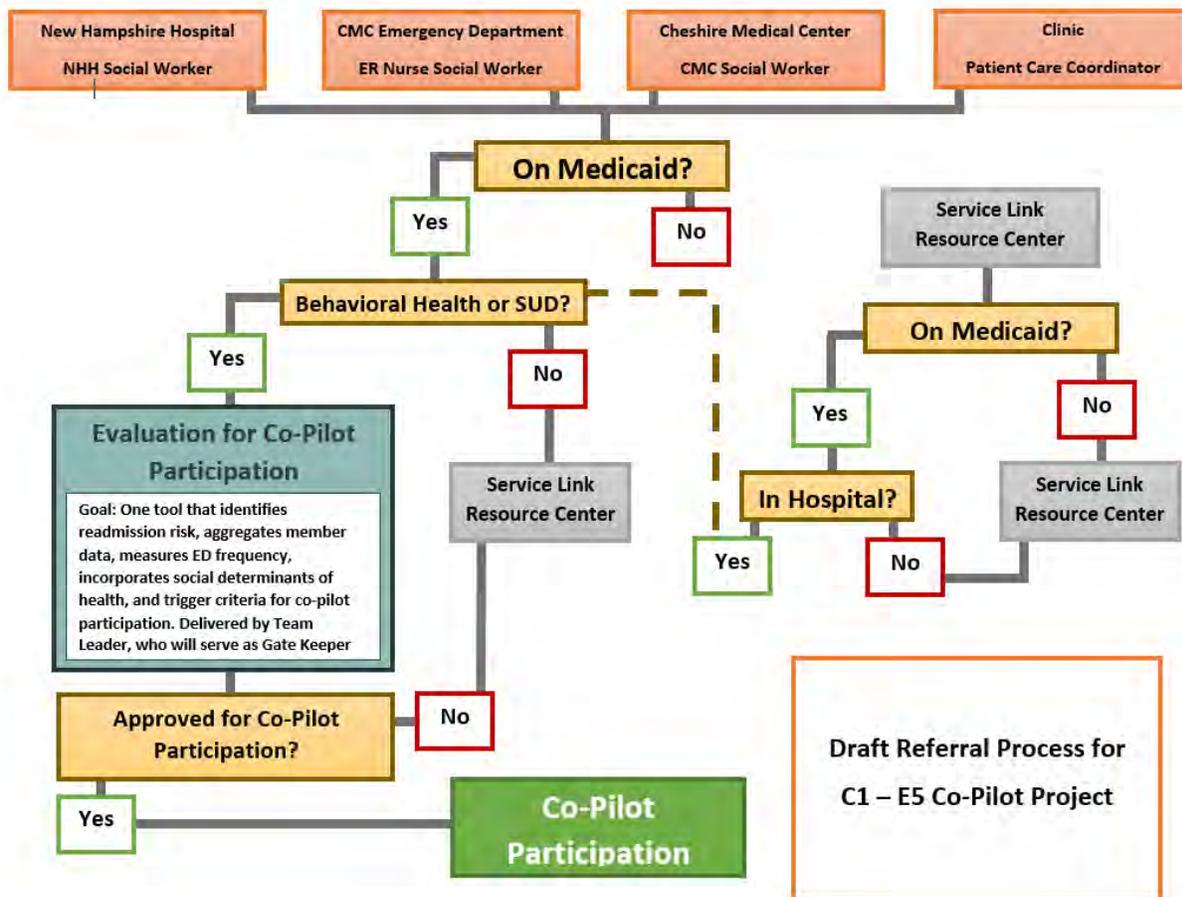
The Co-Pilot team with the support of IDN project management and the QI facilitators from CHI were able to work through the end to end patient process for both treatment avenues of the co-pilot project for patient assessment and referral. The team with support from clinical staff at Cheshire medical center were able to map the opportunities pre-discharge for coordinator to patient linkage. Allowing for a warm hand off for those patients eligible for CTI case management services. For high acuity patients who are not able to access the CTI coordinators the same initial screening and referral process will link these patients to the more generalized care coordination staff supported by the project. The referral form being used by the team for the time being is being stored in Excel and captures very minimal information. The function of this tool is to serve as a first touch for the team lead and to streamline the transfer of a patient into one of the project flows. Once a patient has been linked to a project stream the coordinators will take over the input of the patient into the formal tracking systems and commence outreach activities. It is the intention of the team to use components of the shared care plan and other IDN supported IT applications to support these flows wherever possible.

Additionally, the Community of Practice sessions supported by CACTI have facilitated an open discussion across 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 still ongoing and the IDN1 team anticipates that as tools are reviewed statewide the group will look to streamline the assessments and protocols where possible leveraging the best practices available to the group through the CACTI contract. 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

See the Referral Mapping below for the new Co-Pilot project team:



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

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

With all project team staff hired, all staff have gone through onboarding and orientation at Cheshire Medical Center, Monadnock Family Services, and the Monadnock Collaborative.

All staff are also trained in person-centered planning, motivational interviewing and case management best practices.

All applicable staff completed the 2-day CTI training held in early fall, 2017. The training guided staff through the phases of CTI as well as introduced new staff to the CTI documents and tools. Examples below:

Any additional staff training will be captured in subsequent reporting periods.

Upcoming training for the C1 project statewide is proposed for March, 2018. For this session Region 1 will pursue interested partners in Sullivan County and the Upper Valley and offer training slots.

Additional Template Form Examples continued in Attachment C.9a

CTI Phase Plan

Phase #:	Pre-CTI <input style="width: 30px; height: 25px;" type="text"/>	Phase 1 <input style="width: 30px; height: 25px;" type="text"/>	Phase 2 <input style="width: 30px; height: 25px;" type="text"/>	Phase 3 <input style="width: 30px; height: 25px;" type="text"/>
Today's date: ____ / ____ / ____	Client's name/DOB: _____			
	Medicaid number: _____			
	Record Number: _____			
Date phase starts: ____ / ____ / ____	Due date for end of phase: ____ / ____ / ____ <i>(blank for pre-CTI)</i>			

GOAL #3 _____

Reason for choosing this goal:

Strategies:

Overall goal:

C-10. 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	Table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	Standard Assessment Tools					
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 attachment D-1a for Implementation Timeline

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Using Microsoft Project or similar platform, provide a detailed narrative which provides progress made on required activities, timelines, process milestones, and progress assessment checkpoints for implementing the IDN's community project.

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

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

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

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

Overview of the PATP-IOP Project: As reported in the July 31, 2017 Implementation Plan

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.

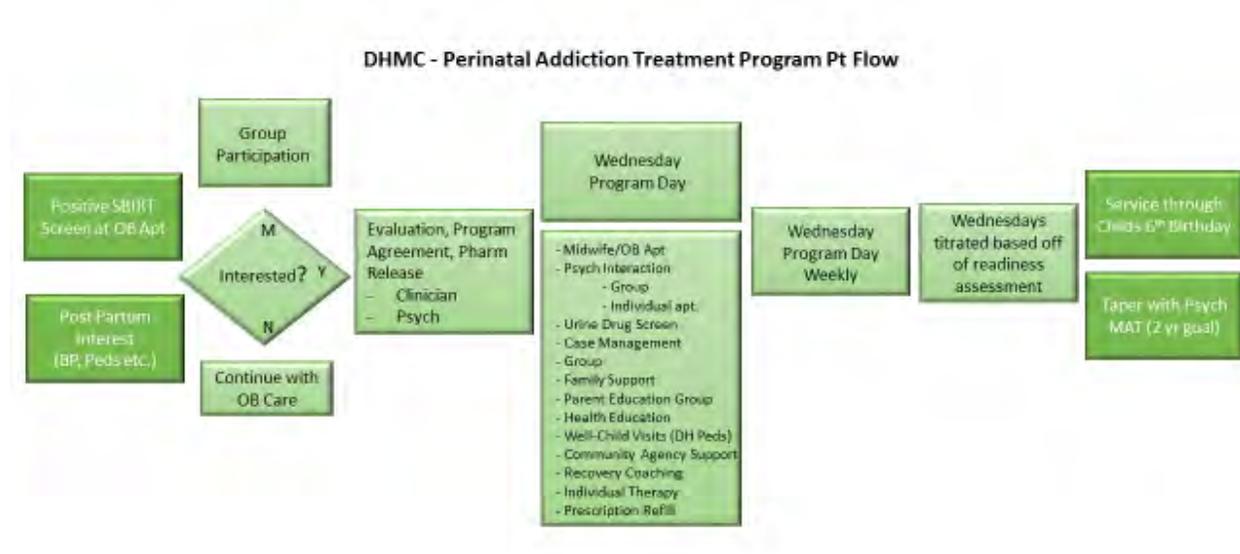
July-December 2017:

During the semi-annual period the PATP-IOP Expansion project team met 2x monthly in person to work on project expansion and the protocols to support programmatic infrastructure change within the project. The PATP hired for 3 additional positions during the semi-annual period and re-allocated current staff to accommodate for the needs of the growing project. The IOP anticipates to launch with its initial cohort by late January, 2018. Initially in the implementation plan submitted July, 2017 this projected date was to commence earlier in the fall but was postponed given delays in securing the correct staff member to provide the childcare component of the proposal. This extension of the clinical rollout of the project allowed for addition staff time and preparedness activities to be focused on new and expanded IOP patients. Some goals for the group moving forward in the upcoming Semi-Annual period:

- 1) PATP-IOP groups begin- January 2018
- 2) Childcare, recovery coaching and case management expanded to third day
- 3) Ongoing evaluation and refinement of PATP structure, policy and procedures and curriculum, with an emphasis on smooth transitions from IOP level of care to outpatient level of care.
- 4) Focus on continuing to engage community partners in PATP program and to facilitate connections between PATP and community agencies
- 5) Continue to enrich program curriculum and refine program structure
- 6) Collect and interpret data regarding outcomes

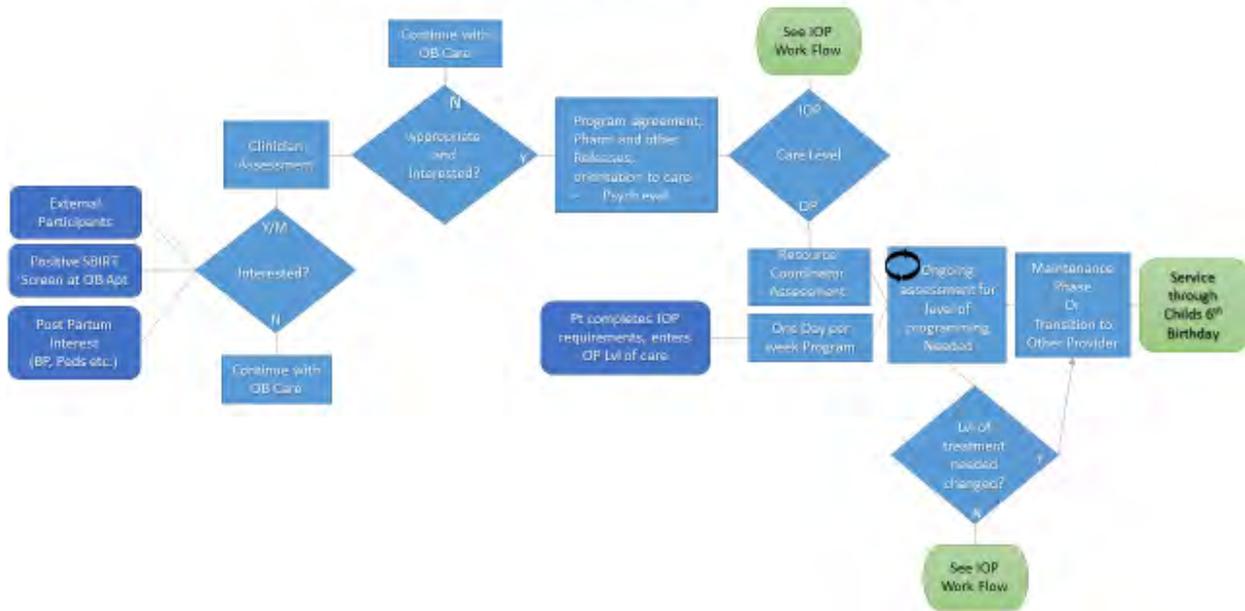
Much of the work completed by the project team throughout July-December, 2017 was focused on mapping their current processes and formalizing the patient, program flows for new program staff and to accommodate for the PATP expansion to 3 clinical days weekly. Please see examples of these workflows below:

Pre-IOP and OP Expansion Patient Flow

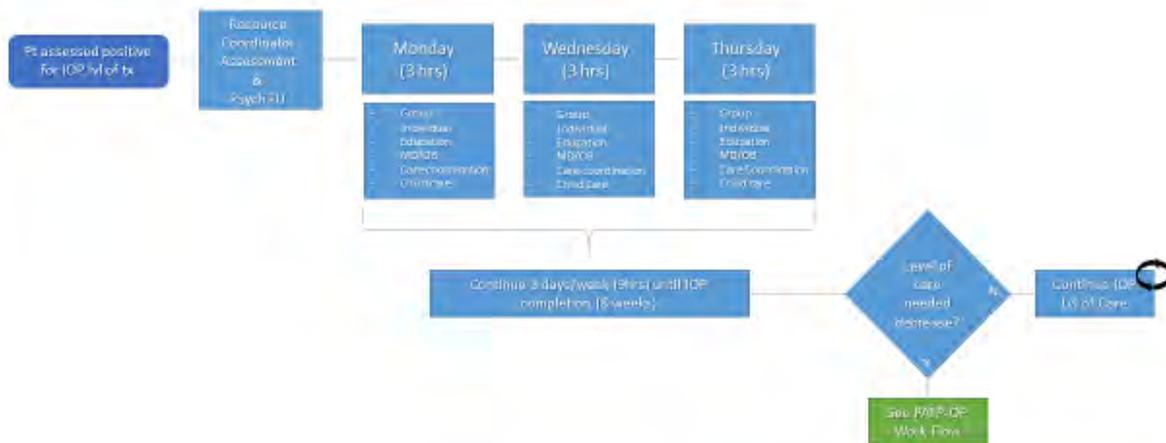


With support from the CHI contracted QI facilitator the D3 PATP-IOP pilot team has crafted their Outpatient (OP) and Intensive Outpatient (IOP) future state program flow and process maps. These are evolving tools but provide a training baseline and framework for the staff to work from as the program expansion incorporates new workflows and systems.

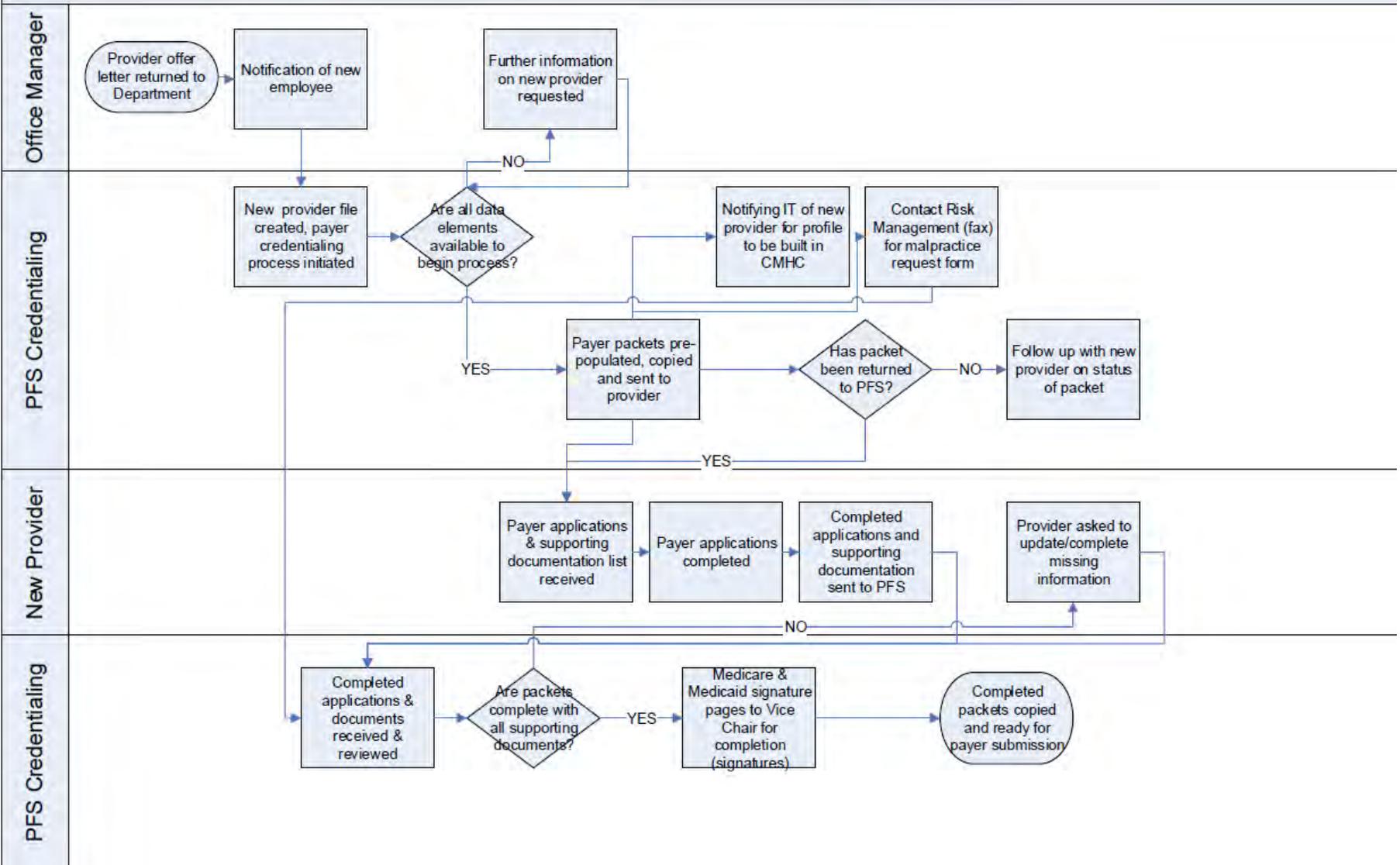
DHMC: PATP-OP Future State Program Flow



DHMC: PATP-IOP Future State Program Flow



New Provider Credentialing – completing the paperwork for submission to insurance



Another key component of the project teams work throughout the past semi-annual period has been focused on community and organizational partner outreach and marketing. The Project team and greater OP staff have worked with resources at DH to endorse their programs and spread the word about the new IOP program. See marketing materials example below:

How to Contact Us

If you have questions or would like more information about our services, contact us at (603) 653-1860 or ask your health care provider for a referral. You may also visit us at: dartmouth-hitchcock.org/psychiatry/perinatal-addiction-treatment.html

Our Address
 Dartmouth-Hitchcock
 Addiction Treatment Program
 Rivermill Complex
 85 Mechanic Street, Suite 3-B1
 Lebanon, NH 03766

Recommended Resources

NH Treatment Locator
www.nh-treatment.org/

Vermont Department of Health
www.healthvermont.gov/alcohol-drugs/help

U.S. Office on Women's Health
www.womenshealth.gov

MGH Center for Women's Mental Health
www.womensmentalhealth.org

Are You Struggling With Opioid Use? You Are Not Alone

Dartmouth-Hitchcock Moms in Recovery is a safe space where you can meet with other women who are in recovery from addiction and get the help you need to stay sober.

What are the Possible Signs of an Opioid Use Disorder?

- Spending a lot of your time and money on getting and using drugs
- Using more than you intend to or having difficulty stopping
- Suffering from sweating, diarrhea, pain and anxiety when you do not use

What is Medication Assisted Treatment?

When you use heroin or other opioids, you are at higher risk for overdose and infections, which can harm both you and your baby.

Metadone and buprenorphine (Suboxone) are commonly used as safer alternatives for women who are pregnant and dependent on opioids.

Who We Are

Moms in Recovery is a program for pregnant and parenting women who struggle with substance use. At Moms in Recovery you will meet other women who are working hard to be good parents and manage their substance use disorder effectively. You will be able to form close relationships with counselors, psychiatrists, midwives, pediatricians, case managers and recovery coaches. These professionals can support you in developing a healthy lifestyle that is rewarding and free from substance use.

Our Services

The Moms in Recovery program offers the following services:

- Medication assisted treatment, including buprenorphine (Suboxone)
- Intensive Outpatient Program for women only
- Group therapy with other mothers and pregnant women
- Individual counseling
- Help with depression, anxiety and PTSD symptoms
- Help accessing housing, transportation, insurance and employment support
- Support for building healthy relationships
- Parenting classes
- Food pantry
- Prenatal and women's health care visits on site
- Supervised playtime for children on site while their moms attend treatment

Additional to these materials the group has sent letters to other SUD providers to inform them about the expanded IOP services and shared the program guidelines. Some agencies receiving information from the PATP are:

- Road to a Better Life
- Groups
- Habit Opco
- WCBH
- Little Rivers Health Clinic
- HOPE for NH Recovery
- Bradford Psychiatric Associates
- Phoenix House
- WISE

The PATP team is looking to support access to the expanded IOP across all areas of western NH and VT.

Formalizing of project materials has not been limited to those resources for external partners. The project team has developed a formal orientation handbook for participants that covers mission, program staff, what to expect, and patient rights. This will serve as a formal guideline for all new program participants and the framework for the IOP and OP orientation.

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 October, November 2017 met and underwent review of the proposed project performance measures. This process included review of ongoing grants and other project components for alignment across evaluation metrics. Seven core performance measures were selected as the foundation for program evaluation. Those measures and their operational definitions can be found below:

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of Medicaid women successfully completing the IOP program				
Number of women engaged in continuing care one month following completion of IOP				
Number of Negative UDS at end of program				
Number of women receiving reproductive health services visit				
Number of pregnant women who attend recommended prenatal visits during program				
Number of women with established PC relationship				
All program participants are screened for SDoH				
STC Defined Program Measures				
<i>All performance measures identified within the evaluation plan milestones</i>	100%	100%		
<i>Operationalization of Program</i>				
A. Implementation of Workforce Plan				
B. Deployment of Training Plan				
C. Implementation of any required updates to clinical protocols, or other operating policies and procedures				
D. Use of assessment, treatment, management and referral protocols	100%	100%		
<i>Initiation of Data Reporting</i>				
A. Number of individuals served vs. projected				
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected				
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	100%	100%		

Operational Definitions of the Evaluation Project Targets:

- 1) Number of women successfully completing the IOP program**
 - o Completion is: 22 sessions completed within an 18 week period
- 2) Number of women engaged in continuing care one month following completion of IOP**
 - o Continuing Care is:
 - Return to OP level of care
 - Transfer to other OP or IOP
 - Discharge to higher level of care
- 3) Number of women with negative UDS at end of program**
 - o Less than 50% testing positive for THC by the end of an IOP
 - o Less than 25% testing positive for any non-prescribed substance other than THC
- 4) Number of women receiving reproductive health services visit**
 - o Health Services visit includes:
 - Daisy G. to supply clinical markers
- 5) Number of pregnant women who attend recommended prenatal visits during program**

6) Number of women with established relationship with a primary care

- At least one visit with a PCP in the past 12 months

7) All program participants are screened for Social Determinants of Health

- SDoH assessment includes :

- Housing
- Financial Strain
- Education
- Social Isolation
- Transportation
- Employment
- Legal Issues
- Interpersonal Safety

- Data pull will include # of positive screens, % month to month, domain area with highest + screens quarterly, annually

With support from a PATP research assistant and leadership from the projects key OB staff the project will ensure all data points needed for measurement review and applicable data extractions will be conducted quarterly. The PATP-IOP team will review monthly to address trends or any risk areas applicable to day to day operation presented in the data pulls.

The creation of a standardized operational definition not only streamlines the process for data retrieval and extraction from the various systems and tracking methods used by the team members it ensures that measures are accessible to all staff. The goal of the evaluation rubrics as proposed is to not only show efficacy across the given programmatic intervention but to highlight areas where additional quality improvement works needs to be undertaken to support greater success and completion for program participants.

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.

The PATP-IOP team has been fully staffed since December, 2017.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
<i>Masters Level clinician (BH)</i>	1 FTE	Recruit to Hire	1.5 FTE		
<i>Psychiatry (MD, ARNP)</i>	.3 FTE	Recruit to Hire	.3 FTE		
<i>OB/GYN(ARNP, CNM)</i>	.1 FTE	Recruit to Hire	.1 FTE		
<i>Pediatrician (MD, ARNP)</i>	.1 FTE	Recruit to Hire	.1 FTE		
<i>Social Work Case Manager</i>	.5 FTE	Recruit to Hire	.5 FTE		
<i>Recovery Coach</i>	.5 FTE	Recruit to Hire	.5 FTE		
<i>Childcare Providers</i>	.75 FTE	Recruit to Hire	.75 FTE		
<i>Administrative Support Staff</i>	.5 FTE	Hired, Utilizing Current Staff	.5 FTE		
<i>Certified Medical Assistant</i>	.5 FTE	Hired, Utilizing Current Staff	.5 FTE		

D-4. IDN Community Project: Budget

Provide a narrative and a brief project budget outlining projected costs to support the community project. After 6/30/17, updates must include financial reporting on actual spending.

No changes have been made to the D3: PATP-IOP project budget. Please see the table below for the awarded budget and the secondary table representing actual project expenditures for the term July 1-December 31, 2017.

Between July 1 and December 31, 2017, the PATP-IOP team expensed \$6239.28 towards the budget in salaries. Due to the IOP launch date many of the other project costs will not be reflected until formal clinical intervention explains. The January-June, 2018 actuals budget will reflect staff training and peripheral p

Organization Name:	D-H				
Project Title:	PATP IOP				
Start and End Date:	7/1/2017 to 9/1/2020				
Budget					
	Year 1		Year 2	Year 3	Totals
<i>Start Date</i>	7/1/2017	Actuals 7/1-12/31/17	7/1/2018	7/1/2019	
Direct Expenses					
<i>Fringe Benefits</i>	\$0.00		\$0.00	\$0.00	
<i>Training/ Workforce Development</i>	\$6,000.00		\$6,000.00	\$6,000.00	
<i>Technology (Pager, Laptop, etc.)</i>	\$5,500.00		\$5,500.00	\$5,500.00	
<i>Recurring Expenses</i>	\$10,000.00		\$30,000.00	\$30,000.00	
<i>One-Time Expenses</i>	\$2,500.00				
Total	\$345,330.00		\$362,830.00	\$362,830.00	\$1,070,990.00
Actuals Total		\$6,239.28			
Indirect Expenses					
Administration (10%)	\$0.00		Year 2, 3 Totals are Unconfirmed		
Billable					

project expenses.

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 changes or alterations to the assessment tools utilized by the PATP-IOP team were made in the July-December, 2017 Semi-Annual period. The team has expanded utilization of the assessment tools and formalized protocols for the IOP.

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 clinicians to access the services available through the PATP-IOP listed below.
	Psychiatric evaluation
	Complete medical and reproductive health history
	Collaborative development of an individualized treatment plan by the participant and her care team, addressing all ASAM domains, medical, and psychiatric needs
	8-week intensive outpatient program with 3 group sessions weekly (9 hours) including psycho-education and evidence-based group therapy utilizing trauma-informed, gender-relevant approaches
	Individual counseling
	Medication assisted treatment when indicated
	Smoking cessation counseling and treatment
	Peer support/recovery coaching
	Case management
	Life skills programming (including skill development regarding parenting skills, healthy relationships, nutrition and self-care)
On-site childcare when mothers are in individual or group therapy	
Urine drug screens and breathalyzer testing	
The PPATP-IOP will incorporate Motivational Interviewing, Cognitive Behavioral Therapy and Dialectical Behavioral Therapy as foundational approaches to addiction treatment, all of which are evidence-based practices. In 2017 the current PATP will begin to incorporate the Circle of Security Parenting Program.	

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

Use the format below to provide a list of all protocols to be utilized for patient assessment, treatment, management, and referrals for the community project. IDNs should indicate what protocols are currently in place and which are slated for adoption. DHHS reserves the right to audit all or a selection of protocols used by the IDNs.

The PATP-IOP project team worked diligently throughout fall 2017 in preparation for the expansion to 3 weekly clinical days to support the PATP IOP. Much of this work centralized around the process mapping and workflows for new patient referral, daily treatment flow, and new process development. With the support of the QI facilitation from CHI the team was able to use process improvement tools to streamline and formalize this work. Two formal protocols born out of this work were the IOP treatment contract and the formal IOP curriculum. Both tools are based off of pre-existing PATP OP frameworks, which are derived from evidence based best practices used at similar programs throughout the country. Blending the strongest components of each project structure to suit the particular needs of this specific population and the culture of the PATP program.

Protocol Name	Brief Description	Use (Current/Under development)
Treatment Contract	Contract specific to the IOP program. Derived from the OP PATP contract framework	In Use
IOP Curriculum	8 week clinical curriculum that guides the PATP-IOP	In Use

D-8. IDN Community Project: Member Roles and Responsibilities

Using the format below, identify team members and their roles and responsibilities for the project. DHHS reserves the right to audit all or a selection of the written Roles and documents used by the IDNs.

During the term of July-December, 2017 the PATP-IOP Pilot project became fully staffed and began project clinical implementation. No significant changes have been made to the team construction or individual roles and responsibilities by job category. Updates will be made as needed in subsequent SAR timeframes.

Project Team Member	Roles and Responsibilities
1.5 FTE Masters Level Clinician	(3 half-time positions in total) (LCSW, LCMHC, LMFT, MLADC), one of whom will serve as Behavioral Health Coordinator, taking a lead role in coordinating the program and supervising case manager, childcare staff, and recovery coach. Provide group and individual therapy, conduct intake process and level of care assessments, develop individualized treatment plan for each client. Provide phone coaching and outreach to strengthen engagement, decrease drop-out rate, and care coordination with outside agencies such as Child Protective Services, Probation and Parole

0.3 FTE Psychiatry	(MD, ARNP) with buprenorphine waiver, who will serve as medical director of program and supervise masters-level clinicians. Provide psychiatric evaluation and psychiatric medication management where appropriate. Provide medication assisted treatment with buprenorphine and/or other medications to address substance use disorders (e.g. naltrexone)
0.1 FTE OB/Gyn	(ARNP, CNM) Provide women’s health services including prenatal, postpartum, and well woman care. Coordinate health education with regard to women’s health and pregnancy related topics. Assist women with establishing care with a Primary Care Physician.
0.1 FTE Pediatrician	(MD, ARNP) Provide well child care and pediatric services to children of enrolled women. Consult to other providers regarding child health. Coordinate health education on pediatric topics.
0.5 FTE Certified Medical Assistant	Assist in check in process, conduct urine drug screens including observed UDS when appropriate, conduct queries in VT and NH Prescription Monitoring Program at intake and periodically. Assist with prior authorization process. Track and coordinate calling patients in for random urine drug screens and pill/strip counts. Occasionally assist in medical procedures with women’s health or pediatric provider (e.g. pelvic exams)
0.5 FTE Social Work Case Manager	(MSW preferred, BSW/BA considered) Conduct psychosocial assessment for each client and assist in connecting with community resources. Coordinate with community providers both for donations and for visits to the program to speak with clients. Track usage of community services. Coordinate health education program; engage community speakers and adjunctive services (i.e. diaper bank, food shelf, dental care, etc.)
0.5 FTE Recovery Coach	Provide peer support services, education, overdose prevention, connection to community recovery resources for enrolled clients. Attend group sessions as scheduled.
0.75 FTE Childcare Providers	Supervise children while parents are in treatment, coordinate volunteer child care aide program, maintain play space, manage registration process for parents using the family support services
0.5 FTE Administrative Support Staff	Schedule appointments, update insurance and contact information, check patients in on arrival, answer phones and convey messages, track completion of intake paperwork and appropriate releases of information. Assist with completion of prior authorizations and prescription data monitoring program queries.

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

D-10. Project Scoring: IDN Community Project Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
D-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
D-2	IDN Community Project Evaluation Project Targets	Table				
D-3	IDN Community Project Workforce Staffing	Table				
D-4	IDN Community Project Budget	Narrative and Spreadsheet				
D-5	IDN Community Project Key Organizational and Provider Participants	Table				
D-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
D-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
D-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				
D-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

See attachment E-1a for the Implementation Timeline

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Using Microsoft Project or similar platform, provide a detailed narrative which provides progress made on the required activities, timelines, process milestones, and progress assessment checkpoints for implementing the IDN's community project.

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

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

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

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

July 1-December 31, 2017:

The coordinated entry project through the term of July-January commenced bi-weekly meetings in September, 2017 with a team of 5 core project team members. Supporting representation from IDN1, Quality Improvement facilitation, VRH clinical staff, and the Sullivan County Continuum of Care. This core team targeted a 6 month work plan based on the implementation timeline and steps proposed in the July, 2017 submission of the SAR.

Core Process Milestones:

- Development of Screening and Barrier Assessment Tools
 - Project team members supported tool review and conducted outreach to project partners for additional assessment
- Release of Information
 - Review of the VT Coordinated Entry forms
 - Meetings with IDN1 HIT/Data support
- All Partner Meeting and Complex Case Management – Leveraging an existing Sullivan County partner development meeting the coordinated entry team

Given significant capacity limitations within the internal team designated to steward the coordinated entry project there were significant delays to the project development. The core team at VRH worked to move forward with project process milestones as possible with the limited bandwidth. The team successfully met in bi-weekly meetings throughout the fall and early winter, 2017. In mid-December, 2017 the project team, senior leadership at VRH, and members of the B1 team met for a 90 minute session to brainstorm next

steps for the project. This meeting yielded some positive reframing but given continued ambiguities in regard to project implementation the project team has paused with meetings to allow for IDN restructuring. The IDN and QI support have been meeting through late December to review the project process thus far and think about potential areas for change:

Areas of Project Success:

- Project was seated within a Critical Access Hospital with indicated assessments of need from the community
- Project was based off a model that is used to address social determinants of health (SDoH), called Coordinated Entry based in VT.
- Aimed to create a “No Wrong Door” policy for those with mental health (MH) and substance used disorder (SUD)
- IDN supported weekly internal team meetings with the VRH Coordinated Referral team
- Discovered champions in the MH/SUD community
- Utilized community partners to help develop the materials for the project
- Framework developed for the Complex Case Management partner meeting
- Review of referral and assessment templates and forms for project use
- Informed the community on project updates and engaged relevant partners in decision making, especially surround the ROI
- Successful collaboration with VRH’s B1 project

Areas of Challenge:

- Communication between Region-1 IDN and internal VRH E5 Team
 - Establishing workflow with to do items and follow up protocol
- E5 Project that was proposed had already been through a three year vetting process in the State of Vermont
- Heavy reliance on a global release of information (ROI)
 - Limited understanding and confusion on the IDN support of ROI development
- Change of leadership at VRH
- Lack of access to the Human Resource Department at VRH
- Job description and positing
 - Limited internal staff capacity to follow up on active applications and schedule for interviews.
- Limited staff capacity within the care coordination team
- Lack of development on assessment and referrals with internal and external partners
- Data points never discussed to track within the systems
 - Limitations to the data sharing regarding consent and non-covered entity participation
- Ability to leverage resources that had already existed in the community to help fulfill requirements
- Limitations to transparency of communication

Alternative Ideas and Ways to Move the Project Forward:

- IDN and Continuum of Care hosted transparent conversation with all community partners at the CPM meeting on February 7, 2018

- Allow community partners to identify areas of forward movement within the scope of work and use community knowledge to reframe and re-implement the project in Sullivan County
- Assess capacity and ability to host hiring and job posting to go through the IDN/ TDI/ DH
- Re-evaluate job description and determine minimum requirements to be beneficial to project
 - Assessment of licensure level needed
 - Benefits of a licensed social worker vs areas that can be filled by a lower level staff individual
- Opportunity for IDN funded administrative support and/or project management
- Work with VRH to assess for any areas of internal capacity for project ownership and support
 - Integration with B1 VRH/CA pilot
- Identify tools and systems that increase communication between project team, IDN, and UNH facilitator
- Assess options for further involvement of the community, potential development of a community advisory board
- Look at opportunities for hiring to originate from City of Claremont or others
 - Explore co-leadership for the coordinator position with VRH and another City organization
- Review project catchment area and expand for access in Newport, Claremont etc.- Sullivan County
 - Opportunities to coordinate with the Sullivan County CoC staff hired at DH
- Explore opportunities for lower level licensure to fill the CTC position and case examples
- Opportunity to link the CTC to B1 and use the MDCT as the referral source for patients to the E5
- Review supervision components and explore alternative options for coordination to provide supervision
 - Core components
 - Support requirements to the staff person
- Review caseload volumes and function
- Organizational assessment of behavioral health organizations- opportunities for linkage
- Speak to the DOC for coordination into a care management community network at point of release or discharge
 - Link to VRH for PC
 - Push to community supports network
 - IDN1 will be connected to the DOC for coordination
- Opportunity to use MCO data to pull patient panel and support identification for the community networks
 - Address capacity to link up to the ECC provided by MCOs and align with IDN projects

Lessons Learned:

- Early coordination with workforce is key to development
- Use the regional resource and expertise of those based in the region to share cultural insights
- Use the resource that is the network of providers in Sullivan County
- Strong benefit to the clearly defined project team roles

What can the IDN offer in support?

- QI Facilitation at all project team meetings

- Funding for PM support for the project
- Direct support at bi-weekly meetings
- Linkage to resource at the IDN level and coordination with IDN network partners

What is needed from a hosting agency?

- Staff time for project development and internal project management
- Commitment to continue funding for the coordinator
- Next steps: Define points of flexibility vs. what is set in regard to project structure

The restructuring and review of the E5 project is still underway with the IDN1 team, QI support, and CoC representative from Sullivan County. Dependent upon how the project is re-deployed the IDN1 team will make a formal application to DHHS for updates to the E5 Implementation Plan. This can be expected sometime in February-March, 2018.

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.*

Project evaluation for the Coordinated Entry pilot is still evolving but the primary evaluation framework presented in the 7/31/17 SAR has been used as the foundational components for project monitoring.

- The evaluation table listed below shares the currently proposed evaluation frameworks for the E5 project. Given the projects current state of restructuring and hold on clinical intervention there have not been any patients seen by the E5 project.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Increased # of Patients referred to Primary Care	<ul style="list-style-type: none"> • 50% of total clients seen referred to a PCP • By 6/30/18: 65% of the total # of clients served referred to a PCP 	N/A		
All CR Staff and Partners ensure Patient Follow up within 2 Business days of contact	<ul style="list-style-type: none"> • Development of Referral, Response within 2 business days for at least 50% • By 6/30/18: 75% of time CCM will attempt some form of contact with a client 	N/A		
At minimum quarterly Continuum of Care Meetings with increased levels of provider involvement	<ul style="list-style-type: none"> • Identification of referral core team, assessment and referral partners • By 6/30/18: 50% attendance among assessment partners 	N/A		

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Assess program impact through number of individuals interested, served and overall program adherence	<ul style="list-style-type: none"> From the point of patient services inception the E5 team at minimum will document all program interest through referrals, all active clients and review program adherence quarterly. *It is anticipated that these measures will be tracked monthly as the program gets underway. 	N/A		

Additional Project Process Evaluation Targets to Date:

Project Name, Lead Organization	Project Milestones :	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
Q1 Y1: July 1, 2017-September 30, 2017						
"Coordinated Referral" Valley Regional Hospital	Milestone 1: Identify Coordinated Referral Core Team	Document Membership	Met	Met - No funds used for Staff or Patients at current state	Met	Met
	Milestone 2: Recruit to Hire Coordinator or Staff	Copy of Hiring Paperwork	Met			
	Milestone 3: Identify and Finalize Assessment Partners	Copy of Assessment Partner List	Met			
	Milestone 4: Identify and Finalize	Copy of Referral Partner List	Met			

	Referral Partners					
Q2 Y1: October 1, 2017- December 31, 2017						
"Coordinated Referral" Valley Regional Hospital	Milestone 1: Screening and Barriers Tool Development	Documented Materials	In Process	Met- Pending submission of Q2 budget	N/A due to Hiring Status	Met
	Milestone 2: Formalize Coordinator Training Plan	Documented Materials	In Process			
	Milestone 3: Formalize Program Guidelines	Documented Materials	In Process			
	Milestone 4: Formalize Implementation Plan and Share with Partners	Documented Materials	In Process			
	Milestone 5: Begin CoC Network Meetings	Documented Schedule and Attendance	Met, All Partners Meeting Outreach December, 2017			

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.

Due to regional position based hiring constraints the Coordinated Entry project has not been successful in hiring the MSW complex case manager/coordinator position. In an effort to support expanded reach the project team has:

- Re-evaluated position salary
- Reposting job position on Idealist, Social Media, Indeed, VRH Website
- Project team participation with HR and support of position applicant review
- Subsequent steps to revise the job description for the coordinator are underway with the overarching project review

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
Coordinator	1 FTE	N/A	Recruit to Hire		
Clinical Supervisor	.1 FTE	N/A	.1 FTE		

E-4. IDN Community Project: Budget

Given the delays to hiring for the project coordinator there has not been significant expenditure of the IDN project funds for the E5 project. No significant changes have been made to the budget rollout or projected expenditure categories

The current budget is under review to accommodate for addition of a project manager capacity to support project redeployment and serve as an incentive for any co-lead organizations.

Due to the current restructuring and postponement of steps for the E5 team there is no actual expenditure for the team to date. There is some recoupment ongoing with the IDN team and the VRH project lead to address any supervisory time allotted throughout the fall.

Organization Name:	Valley Regional Hospital				
Project Title:	Coordinated Referral				
Start and End Date:	7/1/2017 to 9/1/2020				
Budget					
	Year 1		Year 2	Year 3	Totals
<i>Start Date</i>	7/1/2017	Actuals 7/1-12/31/17	7/1/2018	7/1/2019	
Direct Expenses					
<i>Training/ Workforce Development</i>	\$1,000.00		\$200.00	\$200.00	\$1,400.00
<i>Technology (Pager, Laptop, etc.)</i>	\$1,837.40		\$385.00	\$385.00	\$2,607.40
<i>Recurring Expenses</i>	\$4,416.00		\$4,267.00	\$4,267.00	\$12,950.00
<i>One-Time Expenses</i>	\$300.00		\$0.00	\$0.00	\$300.00
Total	\$92,423.40		\$87,818.00	\$87,818.00	\$268,059.40
Actuals		\$3,360.00			
Indirect Expenses					
Administration (10%)	\$3,530.00		\$8,743.00	\$8,743.00	\$21,016.00
Total Expenses	\$95,953.40		\$96,561.00	\$96,561.00	\$289,075.40
Year 2, 3 Totals are Unconfirmed					

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.

All partners listed below in the organizational table were named in the project proposal and are represented in the All Partner community meetings. Additional organizations are part of the All Partner meeting network and supporting the ongoing community conversations on the E5 project deployment. Depending on project restructuring the IDN1 team will formally onboard additional key organizational participants.

Organization/Provider	Agreement Executed (Y/N)
Valley Regional Hospital (Lead)	Y
West Central Behavioral Health	Y
HOPE for Recovery NH	Y
Claremont Soup Kitchen	Y
Sullivan County United Way	Y
Claremont Emergency Services	Y
Newport Emergency Services	Y
TLC Family Resource Center	Y

Organization/Provider	Agreement Executed (Y/N)
DCYF	Y
ServiceLink	Y
Sullivan County Department of Corrections	Y

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

Standard Assessment Tool Name	Brief Description	Updates as of 1/31/18
VRH: Screening Referral Tool	Simple household information sheet completed by a Referral Partner Agency to capture personal information to provide an initial referral to an Assessment Partner Agency	<ul style="list-style-type: none"> Draft referral process in place
VRH: Barriers Assessment	Needs assessment completed by an Assessment Partner Agency to determine triage level and existing barriers to accessing preventive care, self-maintenance, and health improvement	<ul style="list-style-type: none"> Internal team review of potential barriers assessment tools

The project team members have been working and assessing current tools in use at VRH and partner organizations to leverage and use in development of the coordinated referral tools

The IDN1 team plans to use the restructuring meetings in January and early February for tool review and utilize the partner meetings to garner additional feedback on referral and barrier tool development. With the intention to provide more support in project tool development for any redeployment rollout. This will include the assessment tools listed above and the templates or evidence based tools to support the ROI and consent forms.

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.

All protocols represented in the table below are still under review for formal project team adoption. Due to significant project development delays stemmed from hiring and milestone attainment there have been no final decisions made surrounding project assessment tools. The All Partners meeting group and project sponsors have begun their discussion and review of potential tools.

Protocol Name	Brief Description	Use (Current/Under Development)
Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT) Prescreen Triage Tool for Single Adults	For this project we will be adopting a modified version of the VI SPDAT. This tool has been utilized in Vermont housing to assist in triaging referrals. The VI SPDAT, VCEH Housing Crisis referral form and VCEH- CE Housing assessment will be modified to assess global risk and need of the population in order to help prioritize referrals. Additionally, the prescreen VI SPDAT tools for youth, families, and individuals will be used. The VI SPDAT is a pre-screening tool for communities that do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of The Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a Full SPDAT assessment first.	Pending Project Launch
Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT) Prescreen Triage Tool for Youth, Families		

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.

Given the current project restructuring there may be alterations made to the key project team members and their responsibilities. Those individuals in positions that are pending potential change are highlighted below in gray.

Project Team Member	Roles and Responsibilities
[REDACTED]	[REDACTED]

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

Training Plan:

Proposed in the July, 2017 SAR submission:

The Coordinated Referral Project will use client-oriented, evidence-based practices and methods determined by their community practice members. At this point in project development the identified approaches are Motivational Interviewing and Strengths-Based Approach models of case management. The project will also draw on the Continuum of Care model, which has been effective around the country in bringing multi-disciplinary stakeholders to the table to coordinate and collaborate for improved outcomes. Additionally, the project will look to leverage current staff training in the Coordinated Entry model developed in 2013 by the Vermont Housing Coalition and the Vermont Coalition to End Homelessness. The Coordinated Entry approach is a framework for creating effective partnerships to collaborate, coordinate, and streamline various community resources for the common goal of serving a target population. The approach was developed in coordination with a variety of service agencies across the state to create a standardized, tested approach. Pilot projects in the state of VT began in early 2014, with state-wide adoption in early 2015. The focus of the approach was not to increase resources through new or larger funding opportunities, but to connect and modify existing resources to create the most effective, integrated system possible. The coordinated aspects of the VRH project are built upon the lessons learned from the VT Coordinated Entry system. If this project is successful in streamlining existing resources to build capacity in partner agencies, it could be replicated throughout the state of NH to maximize other programs.

Additionally, since the approach was developed in Vermont, there is considerable opportunity for implementation support, contracted training and tool sharing. The high level milestones to implement Coordinated Entry in the Continuum of Care network structure are as follows:

- Completion of Local CoC Coordination Entry Orientation: Much of this work for the Coordinated Referral project at VRH has been completed in their project application and pre-work to implementation.
 - Execution of Coordinated Entry Partnership Agreements: See the form to be used by the VRH team below.
 - Execution of Data Sharing Agreement: Support from the Region 1 ID/Data group and required data sharing agreements across IDN partners.
 - Shared Release of Information: Support from the Region 1 Privacy and Legal workgroups
- Creation of Local Resource Inventory: The Sullivan County Public Health Network and existing CoC structure will support and aid in the development of this inventory as it will be made available to all area agencies

Updates on the Training Plan for the semi-annual period July-December, 2017

Since the inception of the project there have been no significant changes to key partner organizations or providers.

Depending on the restructuring of the E5 project there may be alterations made to the proposed training plan to accommodate for new project components.

E-10. Project Scoring: IDN Community Project Process Milestones

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
E -1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
E -2	IDN Community Project Workforce Staffing	Table				
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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, a “plan to plan”, currently under CMS review, articulates the process by which the state will work with the IDNs, Medicaid managed care organizations (MCO), and other Medicaid services stakeholders, develop a statewide APM workgroup and develop 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. Each IDN will be required to develop an IDN-specific APM Implementation Plan. Once finalized and CMS approved, the DSRIP APM Roadmap will be posted to eStudio.

APM-1. Project APM Scoring: IDN Participation in Statewide APM Taskforce and Implementation Plan Development and IDN APM Implementation Plan

Use the format below to identify the IDN’s participation in Statewide APM Taskforce activities, completion of a Statewide APM Implementation Plan, and completion of the IDN APM Implementation Plan. Of note, all IDNs must participate in the development and writing of a Statewide Implementation Plan. Should the Statewide APM Implementation Plan not be completed, all IDNs will receive a “no” for this effort.

Lynn Guillette, VP of Payment Innovation at Dartmouth Hitchcock and member of the IDN1 Executive Committee has been named the primary IDN1 APM liaison for the DHHS sponsored APM workgroup. Lynn 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. 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.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners	Met		
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Met		
Completion of the Statewide APM Implementation Plan	In Process, Fully Supported by IDN1		

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participation in the creation of the IDN APM Implementation Plan	Met		

DSRIP Outcome Measures for Years 2 and 3

Each IDN may earn up to 10% of the total IDN performance funding in Year 2 (CY 2017) and 25% of the total performance funding in Year 3 (CY 2018). The Table below, provided for information only, includes the DSRIP Outcome Measures that will be used for incentive payments for Years 2 and 3. For Years 2 and 3, use the current DSRIP Outcome Measures that must be reported as indicated in the Table below; cross reference to the final DSRIP Outcomes Measures documentation, located in eStudio. For additional information regarding Years 2-5 incentive payment mechanics, see the STCs, Attachment D, located in eStudio.

For Years 4 and 5, CY 2019 and 2020, 100% of the performance funding will be based on the DSRIP Outcomes Measures. See the DSRIP Outcomes Measures, available on the DSRIP website, for more information.

DSRIP Outcome Measures		
Year 2 (CY 2017) Incentive Payment for Reporting Measures	Year 3 (CY 2018)	
	Incentive Payment for Reporting Measures	Incentive Payment for Performance Improvement Measures
Use of Comprehensive Core Standardized Assessment by Medicaid Billing IDN Providers	Recommended U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by IDN Providers (reporting)	Physical Health-Focused HEDIS Measures for BH Population: Summary Score (reporting)
Appropriate Follow-Up by Medicaid Billing IDN Providers for Positive Screenings for Potential Substance Use Disorder and/or Depression	Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by Medicaid Billing IDN Providers (reporting)	Experience of Care Survey: Summary Score
Conduct IDN Baseline assessment of current use of capacity to use APMs among partners	Timely Transmission of Transition Record After Hospital Discharge (reporting)	Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Develop an IDN-specific roadmap for using APMs	Potentially Avoidable Emergency Department Visits
		Follow-up After Emergency Department Visit for Mental Illness Within 30 Days
		Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days
		Follow-up After Hospitalization for Mental Illness Within 7 Days
		Follow-up After Hospitalization for Mental Illness Within 30 Days
		Extended Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose

