



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

For  
Year 4 (CY2019)  
2019-01-31 v.27

FINAL DRAFT – REDACTED SUBMISSION  
Region 1 IDN

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## 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.

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*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.*

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See below for illustration of attachment for project B1 deliverable 2A:  
Attachment\_B1.2A

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

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

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

## DSRIP IDN Project Plan Implementation (PPI)

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

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

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

## DSRIP IDN Process Milestones

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

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

### Soliciting Community Input:

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

Initial engagement efforts included:

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

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

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

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

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

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

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

## Network Development:

(All updates by reporting period shared in bullet format)

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

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

*Updates for Semi Annual Period: July-December, 2018*

- Given the point in project implementation the IDN is not onboarding many new partners but has added Stepping Stones & Next Step Peer Support and Crisis Respite Centers as well as Reality Checks in CY2018. Additionally, the IDN is always open to new partner engagement and assessing an organizations fit to join the IDN network. This process has been formalized by the IDN executive committee and includes questions for any new onboarding organizations and identifies if the service provided fills a current IDN gap area. This identification and vetting also weighs the organizations Medicaid penetration.

**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, 2018*

- The IDN team continued to refine the Integrated Care Team pool of organizations and providers throughout 2018 in an effort to concentrate support and financial incentive to those organizations with the most significant population.

**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, 2018*

- Given ongoing funding uncertainties throughout CY2018 IDN1 per instruction from the Executive Committee held on expanding the community projects into new geographic sub-regions. The only new onboarding projects were those designated in B1: Coordinated Care.
- Additionally, the IDN administrative team released four workforce RFA’s throughout the term to support the following:
  - Recruitment & Retention, Loan Repayment, Supervision and Internship Capacity
  - Community Supports Agencies (addressing social determinants of health) – 2 Rounds released
  - Peer Support (both for mental health and substance use disorders)

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

*Updates for Semi Annual Period: July-December, 2018*



- 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
- IDN1 continues to serve as a connector between network partners and new funding opportunities related to expansion of SUD services. Given the notification of additional funding coming into the state in fall, 2018 the IDN1 team will work to connect partners and support their efforts to pursue new funding streams.

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

- All Together SUD Meetings in the Upper Valley
- The Governor’s Opioid and Other Drugs Commission Healthcare Taskforce
- NH Commission on Primary Care
- Insurance Department Advisory Board on Behavioral Health and Addiction
- Clinical Trials Network
- Involvement on the 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

Updates for Semi Annual Period: January-June, 2018

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

Updates for Semi Annual Period: July-December, 2018



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

Updates for Semi Annual Period: July-December, 2018

- The IDN1 team held the fall, 2018 advisory council at the Common Man in Claremont in September, 2018. See below for Agenda:
- The IDN team is in planning for a January 31<sup>st</sup> AC to celebrate 1 year+ of project implementation

DSRIP 1115 Waiver  
 IDN Region #1: *Partnership for Integrated Care*  
 September 13, 2018  
 Fall Advisory Council Meeting: *Projects, Performance & Patient Impact*



Time	Topic	Leader
8:30 – 9:00	Networking Coffee	
9:00 – 9:15	Welcome & Updates	Dennis Calcutt, Chair, Region 1 IDN Executive Committee & Ann Landry, Region 1 Executive Director
9:15 – 9:30	Journey from Recovery to Community Health Worker	Alexander Annunziata, AmeriCorps Volunteer, Recovery Coach, Patient Representative
9:30 – 9:45	Multidisciplinary Core Team in Action	Michelle Lin, DH/WCBH B1 Care Transitions Coordinator, Matt Duncan, DH Psychiatry, Tyler Vogt, DH Primary Care & Joanne Wagner, DH Behavioral Health Consultant
9:45 – 11:30	Project Updates & Panel Discussion <ul style="list-style-type: none"> <li>Project Updates (35 minutes)</li> <li>All Projects Panel Discussion (55 minutes)</li> <li>Privacy &amp; Consent Panel Discussion (15 minutes)</li> </ul>	Jessica Powell, Region 1 Program Director, Integrated Healthcare & Community Project Teams
11:30 – 12:15	Networking Lunch <ul style="list-style-type: none"> <li>Table Top Discussions</li> </ul>	
12:15 – 1:00	Data & Quality Reporting Updates: Transforming Data into Action <ul style="list-style-type: none"> <li>Self-Site Assessments Analysis &amp; Next Steps (30 minutes)</li> <li>Quality Reporting Update (15 minutes)</li> </ul>	Marcy Doyle, Citizens Health Initiative Mark Belanger, Region 1 IDN HIT Director
1:00 – 1:50	Workforce Workshops <ul style="list-style-type: none"> <li>Group A: Training &amp; Education Needs</li> <li>Group B: Recruitment, Hiring &amp; Retention</li> <li>Group C: Community Support Agencies: Expanding Capacity</li> </ul>	Peter Mason, Region 1 IDN Medical Director, Ann Landry & Jessica Powell
1:50 – 2:00	Wrap-Up & Next Steps	Admin Lead Team

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

*Updates for Semi Annual Period: July-December, 2018*

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

**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, 2018*

- The IDN1 Data & IT workgroup continued to meet and make progress on team targets throughout the fall, 2018.
- The group is sharing data and consistently reviewing as transparently as possible.
- The workgroup continues to review and support the IDN1 overarching data and IT rollout
- Much of the work in the next semi-annual term is anticipated to center around the shift to pay for performance and supporting ongoing communication to partners on this process

## Budget

IDN-1 has continued through the project implementation and capacity building stages of project development to invest in the learning infrastructure of our region. Supporting activities have been undertaken and funded to target supporting knowledge exchange activities and the dissemination of evidence based and best practices across IDN partners. Much of the last semi-annual period has been invested in planning and using data-driven decision making to successfully target and allocate funding across the project areas and statewide initiatives. Region 1 has remained conservative with its spending during this planning period. Due to the funding uncertainties first identified in December of 2017 and have continued throughout this reporting period, the Region 1 IDN Executive Committee voted to withhold expansion of the Community Projects and 50% of the Workforce Funds in order to commit full funding for current B1 and Community Projects as well as the required HIT infrastructure costs.

The budget below reflect expenses for last six months (7/1/18 – 12/31/18) and the last 12 months (1/1/18-12/31/18). Once the funding uncertainties are resolved at the state level, IDN 1 will revise its budget to reflect any reduction in funding, approved revisions to the implementation plan (based on funding changes) and an increased contingency to reflect potential uncertainty in 2019 and 2020.

See below for a budget reflecting projected expenditures across projects through CY2021- this budget has been constructed to include all known components of IDN operations and projects to date by CY but is subject to change. We anticipate that all project contracts and awards will have been made in CY2020. The projected remaining administrative overhead will be for audit and review purposes.

REDACTED TABLE



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

*Updates for Semi Annual Period: July-December, 2018*

- IDN1 continues work with all of the contract HIT vendors and has adjusted for more on the ground time from MAeHC to support partner organizations in baseline data reporting and the first year of quality reporting submission.

**Integration Assessment:** A contract was supported by the Region 1 Executive Committee to subcontract with the NH Citizens Health Initiative to provide a tool for integration assessment across the B1 providers. The term of funding will cover 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, 2018*

- IDN1 launched the 3<sup>rd</sup> round of the SSA across the B1 partner pool in late November, 2018 and will expect to wrap up in early January, 2019.
  - A scheduled roll up report debrief with UNH will take place in February
- IDN1 is committed to SSA's at minimum annually for the duration of the waiver implementation but given significant barriers to project completion may look at the feasibility of reducing frequency from every 6 mos.

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

*Updates for Semi Annual Period: July-December, 2018*

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

# Project A1: Behavioral Health Workforce Capacity Development

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

*See Appendix A1-3 for Excel Work plan of A1 Activities*

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

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

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

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

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

The Region 1 team continued to focus its regional workforce efforts during this reporting period on securing and retaining staffing levels for the ten projects and providing necessary training to the new hires and newly formed teams. Similar to previous reporting periods, the contracting and recruitment to hiring phase took longer than anticipated for all positions. Region 1 successfully filled needed positions with the remaining two projects. Building from learned experiences with previous project launches, Region 1 incorporated incentive opportunities for sign-on bonuses, loan repayment and relocation reimbursements for all project contracts. Additionally, the team offered retention bonuses to those key B1 and community project positions hired previous to this new approach. Upon hiring the new personnel, all teams immediately shifted to providing the new hires and new teams with the trainings required to implement the specific projects. IDN 1 shifted to an incentive-based contract approach to B1 support organizations which enables these organizations to hire additional resources as needed to meet the requirements of the project. The Region 1 team continues to examine and evaluate how to standardize the onboarding process for the B1 Care Coordinator position, allowing for the local customization as needed. In fact, Region 1 IDN has shared these onboarding processes with other IDNs and Myers & Stauffer Learning Collaborative (MSLC) as requested.

Beyond providing direct funding to projects, IDN 1 continued to think creatively on how to support partners' strategies to expand workforce capacity. This capacity includes organizations' abilities to not only bolster recruitment and retention efforts but also to facilitate closed loop referrals and address the social determinants of health needs of the Medicaid beneficiaries. Through direct support from the Region 1 Executive Committee and DHHS, the team issued a Community Supports Agency Fund RFA allowing social services partners to apply for funding to expand capacity to address the social needs including housing stabilization, vocational training and transportation, to name a few. The Executive Committee approved just over \$250,000 across nine organizations. Recipients of these awards will be allocating funds to housing stabilization coordinators, sober housing specification study, transportation and vocational training for those in recovery, peer recovery outreach and education, development of community referral partnerships, cell phone technology for pregnant woman and new mothers, and a roving advocate to support those suffering from domestic abuse in rural areas. All recipients are connected to IDN 1 integrated healthcare and/or community projects in respective geographies

IDN 1 also released the second phase of the Workforce Request for Funds in December for \$570,000 for use in January to June 2019 to support individual organizations' strategies around Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, and Organization Capacity Support for Internships. The RFA incorporated pre-determined monetary buckets for each category; the amounts within each bracketed were based on the feedback from partners on how workforce capacity needs have evolved since the release of the first RFA in February of 2018. Many partners expressed the value of the sign-on bonuses and loan repayment incentives in recruiting behavioral health staff. However, during this iteration, our partners expressed the high need for funds to support retention strategies. As reimbursement rates for Medicaid haven't increased in several years, behavioral health providers struggle to award the much deserved market rate adjustments. Thus, the executive leadership teams are looking for innovative retention strategies to keep their trusted and respected staff members. Due to the funding uncertainties and the need to keep current required projects fully funded, the Region 1 Executive Committee approved the release of only 50% of the approved workforce budget within each of the above-mentioned categories. IDN 1 will look to release a second RFA in late spring for the second half of 2019 contingent upon the state funding for the DSRIP program.

Region 1's Executive Committee also authorized the release of a second Community Support RFA at the end of December to invest the unallocated \$75,000 from the first RFA in the fall. The RFA specified these dollars to be used specifically on transportation, housing stabilization and food insecurity – three of the highest needs emerging from the social determinants questions in the Core Comprehensive Standardized Assessment. Additionally, the IDN 1 team released a RFA specific to programmatic development for Peer Support inclusive of peer support for mental health and peer recovery coaching for those with substance use disorders; this RFA avails \$145,000 of funds.

All of the above-mentioned RFAs are due January 25<sup>th</sup> with a decision to be made at the February 14<sup>th</sup> Executive Committee meeting.

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

Region 1 continued during this reporting period to support all Statewide Workforce Taskforce activities, currently serving on all four sub-committees and attending all statewide meetings. Region 1 strongly supports any opportunity to centralize cross-IDN efforts to improve workforce capacity through the statewide objectives outlined in the implementation plan. As always, Region 1 will continue to align its regional efforts with the statewide efforts and pooling resources where appropriate to enhance the overall value in addressing the behavioral health workforce challenges.

### Education and Training

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

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

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

This networking is continuous throughout each reporting period, and discussions with Region 1 partners are ongoing regarding their training needs. Region 1 is addressing most of the requested trainings relevant to the 1115 Waiver which included best practices for integrated care, certified recovery support workers, smoking cessation, alternative payment models, MAT, and SBIRT. Region 1 IDN played an active role in developing the IDN training track at the New Hampshire Behavioral Health Summit to ensure the curriculum offered required trainings and were recorded for dissemination. For additionally requested trainings such as vocational training, combatting bullying or in-depth training for autism in adults, the Region 1 team continues to explore opportunities to meet these needs at the Statewide Taskforce and locally.

The Region 1 Medical Director continues to work as part of a team with CHI/JSI to do the final editing on the Addiction 101/MAT "Roadshow" presentation, designed to educate primary care practices contemplating initiating MAT programs. The project has an expected completion date in March of 2019. At Alice Peck Day Memorial Hospital, the model site for overcoming barriers to expanding MAT in primary care, all of the providers in the Multi-Specialty Clinic are now waived and providing MAT. In addition, a robust counseling program, including warm hand-offs and team co-ordination, has begun in collaboration with Headrest. Region 1's Medical Director continues in an advisory/facilitator role in that practice; and the program facilitation process utilized in developing this collaboration is serving as a foundation for the nascent B1: Integrated Healthcare project there.

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

The Medical Director has determined that adequate existing capacity exists for Recovery Coach training through NHADACA, and we intend to commit IDN dollars to support regional partners in this initiative as indicated through the execution of two peer recovery support contracts (one specifically funding Recovery Coach Training Academy) and the release of the recent RFA directed at Peer Support in December 2018. However, more infrastructure needs to be developed in practices for utilizing coaches before significant investment in Recovery coach training. IDN 1 will re-evaluate its budget to support peer recovery workers after the funding uncertainties are resolved and the evaluations from recent funding are received.

During this last reporting period, Region 1 IDN has continued to refine its strategy to meet all of the training needs of its partners including required project trainings and requested or optional trainings. Region 1

continued to proactively partner with other regions to leverage monetary resources to bring group trainings to the IDNs and to centralize training opportunities. IDN 1's Medical Director (also chair of Workforce Workgroup) and Executive Director redirected time allocated for solidifying the training strategy to support the Commissioner's county strategy for returning IDN funds. As Region 1 sits in five counties, this time commitment in July and August turned out to be substantial. The team remains committed to the county funding strategy at a state and local level; IDN 1 already has meetings booked in January in one county to prepare for 2019 funding. Additionally, the team intends to shift its monthly Knowledge Exchanges now that the required trainings have been completed to share best practices and learnings from the B1 project sites. As refreshers for certain trainings are needed, IDN 1 will work to offer those in-person across the region or through webinars with inclusion on the IDN 1 website.

Region 1 IDN ultimately sponsored or sent partners to the following trainings from July to December 2018:

Training	Month	Required	# of People Trained	# of Participating Partner Orgs	Audio/Materials Available on Website	Financially Sponsored/ Supported by IDN 1
Motivational Interviewing Strategies Overview	July	No	Available to all partners	Available to all partners	Yes	Yes
Mental Health First Aid Training – Youth	July	Yes	27	3	No	Yes
Navigating Medicaid Changes for Prevention, Treatment, and Recovery	July	No	9	8	No	Yes
Addiction 101	September	Yes	27	13	No	Yes
Cherokee Integrated Healthcare Training	September	No	14	10	No	Yes
Mental Health First Aid Training – Adults	September	Yes	23	9	No	Yes
Motivational Interviewing Training – 2 days	September /October	No	21	10	No	Yes
Co-Occurring Disorders	October	Yes	Available to all partners	Available to all partners	Yes	Yes
Mental Health First Aid Training - Youth	November	Yes	23	3	No	Yes
Mental Health Awareness Training	November	Yes	Available to all partners	Available to all partners	Yes	Yes
Preparing for Risk-Contracts	December	No	Available to all partners	Available to all partners	Yes	Yes

Medication-Assisted Treatment (MAT) Training	December	Yes	Available to all partners	Available to all partners	Yes	Yes
NH Behavioral Health Summit IDN Track: The Community Care Team	December	No	35	18	Yes (will be once finalized)	Yes
NH Behavioral Health Summit IDN Track: Understanding and Addressing Substance Use Disorders as Chronic Medical Conditions	December	Yes	35	18	Yes (will be once finalized)	Yes
NH Behavioral Health Summit IDN Track: Enhanced Care Coordination for High Needs Populations from Multiple Perspectives	December	No	35	18	Yes (will be once finalized)	Yes
NH Behavioral Health Summit IDN Track: Core Competencies for Primary Care Behavioral Health Integration: Knowledge, Skills & Attitudes	December	No	35	18	Yes (will be once finalized)	Yes
NH Behavioral Health Summit IDN Track: Chronic Disease Information for Behavioral Health Providers	December	Yes	35	18	Yes (will be once finalized)	Yes
NH Behavioral Health Summit IDN Track: Facilitated Integrated Care Success with Co-Occurring Disorders	December	Yes	35	18	Yes (will be once finalized)	Yes

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

Region 1 IDN has already scheduled/sponsored the following trainings in 2019:

- Motivational Interviewing – 2 days (January/February)
- Circle of Security Training (January/February)
- MATCH Training (February)

- Motivational Interviewing – 2 days (March)
- Cherokee Integrated Healthcare Training (June)
- Finalizing the contract with West Central Behavioral Health on sponsoring 6 additional Mental Health First Aid trainings in IDN 1 in 2019

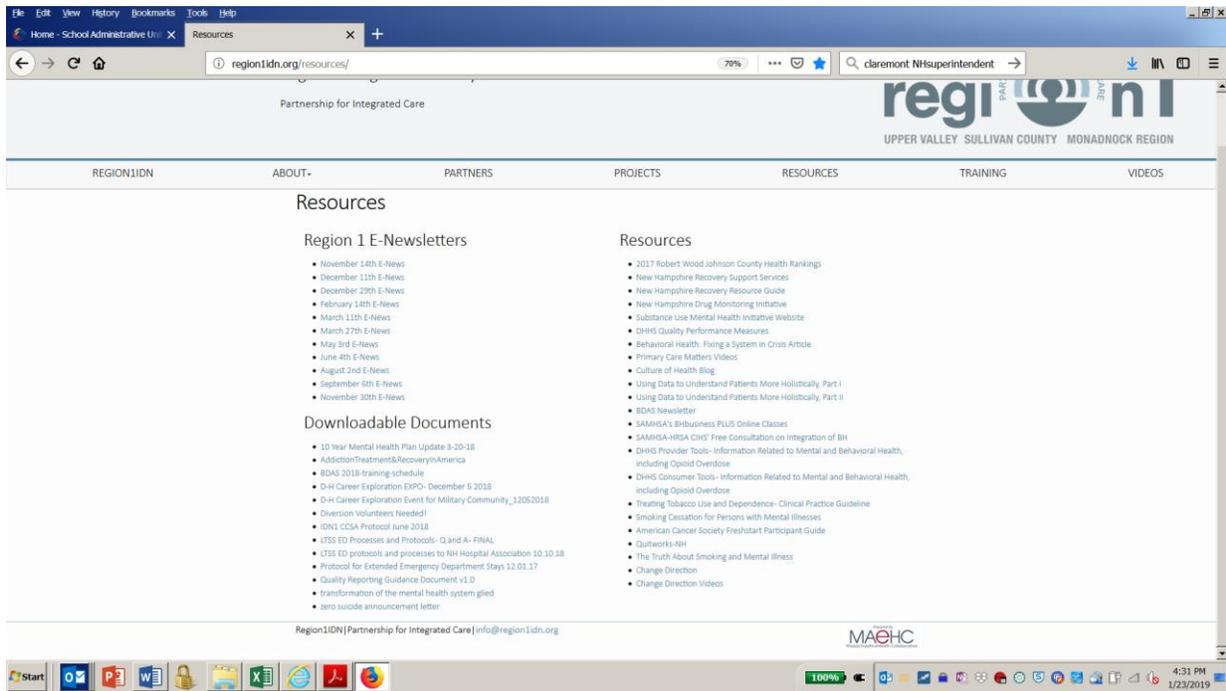
The IDN1 team has also continued to provide privacy and security advisory support to all Partners to facilitate expanded information-sharing among IDN1 partners through these partner trainings.

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

The screenshot shows a web browser window displaying the 'Training' page on the Region 1 IDN website. The page is organized into three main sections:

- Required Trainings:**
  - Knowledge Exchange Session IV- Diabetes Training
  - Knowledge Exchange Session V- BI Required Tobacco Training
  - BI Required Training- Managing Chronic Disease in Behavioral Health Patients
  - Knowledge Exchange VII- Mental Health Awareness
- Additional Trainings:**
  - New Hampshire 8 Hour MAT Waiver Trainings
  - NH Children's Behavioral Health Workforce Development Network (the Network)'s Online Trainings
  - Knowledge Exchange Session I- History of Behavioral Health
  - Knowledge Exchange Session I- Navigating Change Management & Preparing for Shared Care Planning
  - Knowledge Exchange Session III- Social Determinants of Health Screening Tool
  - SAMHSA's Peer Navigators Support People with Serious Mental Illness
  - Review of Bi-State Recruitment & Retention Conference
  - Health Leads' Social Needs Workshop
  - May 22nd Privacy & Consent Partner Training
  - Knowledge Exchange Session V- Trainings & Resources
  - Knowledge Exchange Session VIII- Motivational Interviewing Strategies Overview
- Supporting Materials:**
  - August & September Training Opportunities
  - BI Integrated Healthcare Required Training- Chronic Disease Management for Behavioral Health Providers- final
  - BI Integrated Healthcare Required Training- Diabetes
  - BI Integrated Healthcare Required Training- Tobacco Treatment
  - CONNECT 11-9-18 The Center
  - Cherokee Health Systems Integrated Care Training June 14-15 2018 Final
  - December 4th Knowledge Exchange MAT BASICS FOR IDN 1
  - December 4th Knowledge Exchange MAT BASICS FOR IDN 1
  - Disclosure of Patient Information in an Integrated Care Model\_IDN 1 Privacy Session
  - FORM B- SUD Services- Authorization and Consent to Disclose Short Form...
  - Fall 2018 Mental Health First Aid Trainings
  - Hiv training 11-2-18
  - IDN1 Privacy and Shared Care Planning May 2018
  - IDN1 Quality Reporting Training 18 April 2018
  - Improving Access & Inclusion for People with Disabilities Trainings
  - July & August Training Opportunities
  - June 27th Knowledge Exchange- Motivational Interviewing Strategies Overview Presentation\_IDN 1
  - Knowledge Exchange 052218
  - LNA-MA-Education
  - MI training flyer 12-13-18
  - NH Community Provider Trainings\_PPANNE EPIC\_July2018
  - November 28th Knowledge Exchange- Mental Health Awareness
  - October 28th Workshop for New Managers & Supervisors-Sponsored by Headstart
  - Region 1 IDN September 13th Fall Advisory Council Meeting 091318
  - Region 1 Review of Bi-State Recruitment & Retention Conference
  - Resilience Flyer
  - September & October Training Opportunities
  - Shared Care Plan Guiding Principles
  - Take-Back-Rv-Sullivan-County-Oct27
  - Charlestown naican event 10-24-18

The browser's address bar shows the URL [region1idn.org/training/](http://region1idn.org/training/). The taskbar at the bottom indicates the system time as 4:25 PM on 1/23/2019.



**Region 1 Representation:**

Peter Mason, MD, Medical Director, Region 1

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

[More details >>>](#)

**Workforce Workgroup**

Date: Nov 20, 2018  
 Location: Webex  
 Start: 2:00:00PM  
[More details >>>](#)

**Workforce Workgroup**

Date: Dec 18, 2018  
 Location: Webex  
 Start: 2:00:00PM  
[More details >>>](#)

**Project Documents**

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

- [Behavioral Health Workforce](#)
- [Health Information Technology](#)
- [Integrated Healthcare](#)
- [Care Transitions](#)
- [Expansion in Intensive SUD Treatments](#)
- [Enhanced Care Coordination](#)

Project A2 - Health Information Technology

region1idn.org/projects/a2.html

UPPER VALLEY SULLIVAN COUNTY MONADNOCK REGION

REGION1IDN ABOUT PARTNERS PROJECTS RESOURCES TRAINING VIDEOS

## Project A2: Health Information Technology Infrastructure to Support Integration

*Develop health information technology infrastructure to support integration*

This project intends to develop the HIT infrastructure required to support high-quality, integrated care throughout the state. Initially, the project will establish a statewide Taskforce with members from across the mental health and substance use disorder provider communities in each IDN, as well as other members who can bring relevant experience and knowledge such as the NH Health Information Organization (NHHIO). The Taskforce will assess the current HIT infrastructure gaps across the state; develop a consensus on HIT priorities related to the demonstration; and identify the infrastructure required to meet demonstration goals. Each IDN will then develop and implement an IDN-specific plan to close its HIT gap.

**Region 1 Representation:**

Mary Beth Eldredge, Dartmouth-Hitchcock Medical Center

Patti Witthaus, Valley Region Healthcare

**Behavioral Health Workforce**

**Health Information Technology**

**Integrated Healthcare**

**Care Transitions**

**Expansion in Intensive SUD Treatments**

**Enhanced Care Coordination**

**Upcoming Meetings**

**Project Documents**

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

region1idn.org/videos.html

## Videos

**Region 1 IDN Winter 2018 Advisory Council Meeting: Tools for Engaging Patients & Families**  
 Tanya Lord, Director for Patient & Family Engagement at the Foundation for Healthy Communities, shares her personal story and provides tools for successfully engaging patients and families.

**Region 1 IDN Winter 2018 Advisi**

**Region 1 IDN Fall 2018 Advisory Council Meeting: Value of Self-Site Assessments**  
 Mary Doyle of Citizens Health Initiative speaks to the importance and value of the Self-Site Assessment to drive integration.

**Region 1 IDN Fall 2018 Advisory ...**

**Region 1 IDN Fall 2018 Advisory Council Meeting: Data & Quality Reporting Update**  
 Mark Belanger, IDN 1 Director of Health Information Technology, provides an update on the IDN's data and quality reporting.

**Region 1 IDN Fall 2018 Advisory**

**Region 1 IDN Fall Advisory Council Meeting: Multidisciplinary Core Team in Action**  
 Listen to the Dartmouth-Hitchcock Heater Road B3 Integrated Healthcare project team demonstrate the value of the multidisciplinary core team through a mock patient review.

**Region 1 IDN Fall 2018 Advisory Council Meeting Keynote**  
 Speaker: Alexander Annunziata  
 Alexander Annunziata shares his personal journey from recovery to community health worker. Alexander serves as an AmeriCorps volunteer, recovery coach and patient reevaluation.

4:32 PM 1/23/2019

## Recruitment and Retention

IDN 1 partners shared success stories of the first Workforce RFA issued in February 2018. Many of the awardees continued to draw down through December 2018; several have asked for extensions on use of funds. Partners were able to secure hires with loan repayment options, sign-on bonuses and relocation reimbursements as well as strengthen supervision and internship programs. Additionally, one organization saw a decrease in attrition rate which the CEO partially credited to the workforce funds.

Based on this success, IDN 1 released the second phase of the Workforce Request for Funds in December for \$570,000 for use in January to June 2019 to support individual organizations' strategies around Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, and Organization Capacity Support for Internships. This iteration evolved based on direct feedback from IDN 1 partners after experiencing respective successes and challenges with the first RFA. As mentioned above, this version allocates additional funding for retention strategies and loan repayment options as well as around supervision and internship support.

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

Additionally, the IDN 1 team released a RFA specific to programmatic development, inclusive of recruitment and retention strategies, for Peer Support – both peer support for mental health and peer recovery coaching for those with substance use disorders; this RFA avails \$145,000 of funds.

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
New BH Clinicians recruited due to enhanced supervision capabilities	Up to 6	0	2	2 (+1 Recruit to Hire Underway) <b>MET</b>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Participants in the annual job fair, expressing interest in Regional BH positions	Up to 50	To be held in Spring; collaboration with other IDNs through Statewide plan.	Region 1 IDN Workforce Workgroup didn't wish to hold a Region 1 IDN specific job fair. Partners struggle with the effectiveness of job fairs in general, attending only out of obligation and the ROI may result in one new applicant. The group recommended leveraging existing job fairs, communicating existing job fairs, exploring an all – IDN virtual job fair and participating in a statewide job fair if hosted.	Region 1 IDN Workforce Workgroup didn't wish to hold a Region 1 IDN specific job fair. Partners struggle with the effectiveness of job fairs in general, attending only out of obligation and the ROI may result in one new applicant. The group recommended leveraging existing job fairs, communicating existing job fairs, exploring an all – IDN virtual job fair and participating in a statewide job fair if hosted.  <b>Due to Target shift in CY2018 the goal as initially defined is no longer relevant. The IDN1 partners determined an annual job fair would not be of value. IDN1 has reallocated resources to support ongoing HR recruitment efforts through RFA and in supporting existing HR efforts.</b>

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.	<p>Region 1 IDN Workforce Workgroup didn't wish to post organization job postings on website; instead Region 1 IDN has measured hits on Region 1 IDN website. The team specifically is driving partners to the training and resources pages.</p> <p>Total Hits:  Jan: 3941  Feb: 4097  Mar: 3639  Apr: 4919  May: 4450  Jun: 5899</p> <p>Total Visits:  Jan: 784  Feb: 809  Mar: 887  Apr: 1384  May: 1397  Jun: 1533</p>	<p>Region 1 IDN Workforce Workgroup didn't wish to post organization job postings on website; instead Region 1 IDN has measured hits on Region 1 IDN website. The team specifically is driving partners to the training and resources pages.</p> <p>Total Hits:  Jul: 4297  Aug: 6575  Sep: 8171  Oct: 8210  Nov: 7723  Dec: 8102</p> <p>Total Visits:  Jul: 1380  Aug: 1708  Sep: 1992  Oct: 2539  Nov: 2377  Dec: 2247</p> <p><b>MET</b></p>
Interviews with "Trailing Partners"	Up to 10	3	3: Still waiting on response from River Valley Human Resources Association to present at meeting	<p>3: Still waiting on response from River Valley Human Resources Association to present at meeting; Developed communication plan/protocol to be shared with partners and external businesses</p> <p><b>MET</b></p>
Applications for Loan Repayment	Up to 20	0	4	4 (this is for the State Loan Repayment program. We have supported multiple partner organizations in supporting multiple employees with Loan Repayment)
Culture Change/Integration education sessions	4	3	0	1 <b>MET</b>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Community forums held to celebrate progress in mental health/SUD care	2	To be held in Spring; collaboration with the other IDNs through Statewide plan	Partners represented on the Region 1 IDN Workforce Workgroup determined that IDN-sponsored community forums would be redundant and a poor use of resources. The group recommends leveraging and supporting existing community forums to celebrate progress in mental health/SUD. Additionally, the group believes that this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan.	Partners represented on the Region 1 IDN Workforce Workgroup determined that IDN-sponsored community forums would be redundant and a poor use of resources. The group recommended leveraging and supporting existing community forums to celebrate progress in mental health/SUD. Additionally, the group believed this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan. IDN 1 participated in sponsoring the NH Behavioral Health Summit in December which celebrated progress across the state in mental health/SUD care.  <b>Due to Target shift in CY2018 the goal as initially defined is no longer relevant. IDN1 partners determined that supporting existing structures would be the best use allocated funds</b>
Educational institutions engaged in the workforce expansion project	3	3	3	3 <b>MET</b>
Meetings with IDN's and AHECs on statewide strategies	2	3	5	5 <b>MET</b>
Collaborative practice curriculum for students implemented at professional schools	Up to 4	1	1: This work is taking place by a team at UNH led by Joanne Malloy	1: This work is taking place by a team at UNH led by Joanne Malloy <b>MET</b>

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

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

Region 1 IDN implemented a decentralized approach to hiring for the IDN projects. Thus, the Region 1 team supported its partner organizations in the necessary recruitment and hiring efforts to staff projects during this past two reporting periods. Region 1 succeeded in fully staffing all of its current projects though the E5 Enhanced Care Coordination project in Sullivan County was restructured and currently requires a part-time contracted facilitator (explained below). Understanding the need to differentiate the IDN project position postings, IDN 1 has continued to incorporate recruitment incentive dollars into each B1 Integrated Healthcare project-based position. Simultaneously, Region 1 IDN also used the Workforce Fund RFA Phase I from the first half of 2018 to address general gaps across our region for behavioral health workforce needs (many of these contracts continued to release funds through December of 2108), including MLADCs, psychiatrists and peer recovery coaches; Phase II of this workforce fund RFA was released at the end of December. The team continues to address these workforce gaps through funding organizations’ recruitment, retention, and education and training strategies at both a state and regional level. Some IDN 1 partners have leveraged the funds released through the Workforce RFA to recruit MLADCs, peer recovery coaches, and interns to be placed within our most vulnerable communities. IDN 1 has executed one contract for peer recovery coaching to be implemented in 2019 and has a pending RFA with additional dollars to be allocated to this area.

Provider Type	IDN Workforce (FTEs)				
	Project ed Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Master Licensed Alcohol and Drug Counselors	Up to 8	0	0	*Workforce Funds contributed to the recruitment of 1 MLADC	*Workforce Funds contributed to the recruitment of 1 MLADC and 1 director of SUD <b>MET</b>
Behavioral Health Care Coordinators	Up to 6	0	5 (B1/C1/E 5)	6	6 (Includes B1 CTC Hires) <b>MET</b>
Psychiatrists	Up to 4	1 *Indicates shift in current staff time to support IDN project implementation	.3 (D3)	.3 (D3)	.3 (D3) <b>MET: Given limited psychiatry staff available this is the only warranted need at current</b>

Provider Type	IDN Workforce (FTEs)				
	Project ed Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Psychiatric APRN's	Up to 2	0	0	0	.2 % FTE Support for Clinical Champions on B1 Projects MET
Clinical Psychologists/Neuropsychologists	Up to 4	0	0	0	Not Met- Given limitation of clinical staff and no presentation of need across projects
Licensed Community Mental Health Counselors and/or Licensed Social Workers	Up to 6	1	1.5 (D3)	2.5 (D3, B1)	2.5 (D3, B1) MET
Peer Recovery Coaches	Up to 10	0	.5 (D3)	.5 (D3)	.5 (D3) MET – Additional to direct staff support the IDN has released several Workforce awards targeting supporting expansion of the Peer Recovery workforce through training and hiring
AmeriCorps- Community Mental Health Workers	6	* Service Year begins in October, 2017	0	3	3 MET

## A1-5: Current Community Project Pilot Staffing

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

organizations will take over the ownership of the project. However, in the short-term, retaining ownership within the IDN provided the infrastructure required to gain early successes.

- All Community Project Staffing is MET for 12/31/18 as required by current project volume.

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	Not Currently Staffed Given Project Restructuring- All Contract Positions
	Supervisor	.1FTE	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated	0.1 FTE, Current Staff: Re-allocated

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

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

Many of the recruitment and retention expenditures in July – December 2018 resulted in partners drawing down on awards from the first phase of the Workforce RFA in the first half of 2018. Region 1 IDN also issued phase one of a Community Support Funds RFA in October to release funds to support partner strategies around addressing the social determinants of health of IDN 1 beneficiaries and to expand capacities of social services agencies to help facilitate the closed loop referrals needed.

Based on the applications, Region 1 IDN Executive Committee approved \$201,537.59 out of \$305,051 requested (see below). [REDACTED]

[REDACTED]

**REDACTED TABLE**

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

Trainings funded during July to December 2018:

- A1 General -

Training	Month	Financially Sponsored/ Supported by IDN 1
Mental Health First Aid Training – Youth	July, September & November	\$8,877
Navigating Medicaid Changes for Prevention, Treatment, and Recovery	July	\$955
Addiction 101	September	\$2405.83
Cherokee Integrated Healthcare Training	September	\$4,796.57
Motivational Interviewing Training – 2 days	September /October	\$5,000
NH Behavioral Health Summit IDN Track: IDN 1 Sponsored Seats and IDN 1's cost for the IDN Track	December	\$7,092.86

- C1: \$4,398.80 for Critical Time Intervention Training; included in the C1 budget
- \$15,325 for the five day MATCH training in 2019 was paid for in 2018; IDN 1 sponsored 5 partners to attend this training.



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

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

Stepping Stone & Next Step Respite Centers and Reality Checks joined as partners in 2018

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Alice Peck Day Memorial Hospital	Hospital Facility	A1, A2, B1
<b>Cheshire County (includes :)</b>	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
<b>Cheshire Medical Center/DHK</b>	Hospital Facility	A1, A2, B1, C1, E5
<b>Child and Family Services</b>	Non CMHC Mental Health Provider	A1, A2, B1
<b>Community Volunteer Transportation Company (CVTC)</b>	Community Based Organization Providing Social and Support Services	A1, A2, C1, E5
<b>Counseling Associates</b>	Non CMHC Mental Health Provider	A1, A2, B1
<b>Crotched Mountain (includes :)</b>	Community Based Organization Providing Social and Support Services	A1, A2,
Adult Residential Services	Adult Residential Services	A1, A2
ATECH Services	Assistive Technology Clinical Consultation	A1, A2
Community Care	Community Care Management	A1, A2, B1
Outpatient Services	Specialty Outpatient Clinics	A1, A2
Crotched Mountain School	Residential Treatment	A1, A2
<b>Dartmouth-Hitchcock Primary Care-Lebanon</b>	Primary Care Practice	A1, A2, B1
<b>Dartmouth-Hitchcock Dept. of Psychiatry</b>	Non CMHC Mental Health Provider	A1, A2, B1, D3
<b>Easter Seals Farnum Center</b>	Other Organization Type	A1, A2
<b>Grafton County (includes :)</b>	County	A1, A2
Senior Citizens Council	Other County Organization	A1, A2
<b>Granite State Independent Living</b>	Home and Community Based Care Provider	A1, A2
<b>Greater Monadnock Public Health Network</b>	Public Health Organization	A1, A2
<b>Greater Sullivan County Public Health Network</b>	Public Health Organization	A1, A2

Headrest, Inc.	Substance Use Disorder (SUD) Provider	A1, A2, B1
Home Healthcare Hospice and Community Services	Home and Community Based Care Provider	A1, A2, C1, E5
Keene Housing	Other Organization Type	A1, A2, C1, E5
Ken Jue Consulting	Other Organization Type	A1, A2
Lake Sunapee VNA	Home and Community Based Care Provider	A1, A2
Lebanon Housing Authority	Other Organization Type	A1, A2
Life Coping Inc.	Non CMHC Mental Health Provider	A1, A2
MAPS	Non CMHC Mental Health Provider	A1, A2
Mary Hitchcock Memorial Hospital	Hospital Facility	A1, A2, B1
Mascoma Community Health Center <sup>1</sup>	Integrated Healthcare Provider (not counted as B1)	A1, A2
Mindful Balance Therapy Center PLLC	Non CMHC Mental Health Provider	A1, A2
Monadnock Area Peer Support Agency	Other Organization Type	A1, A2, C1, E5
Monadnock Center for Violence Prevention	Community Based Organization Providing Social and Support Services	A1, A2
Monadnock Collaborative	Other Organization Type	A1, A2, C1, E5
Monadnock Community Hospital	Hospital Facility	A1, A2, B1
Monadnock Family Services	Community Mental Health Center	A1, A2, B1, C1, E5
Monadnock Region System of Care	Non CMHC Mental Health Provider	A1, A2, C1, E5
NAMI New Hampshire	Non CMHC Mental Health Provider	A1, A2
New London Hospital and Medical Group Practice, Pediatric Care Center Practice, and Newport Health Center	Hospital Facility, Primary Care Practice	A1, A2, B1
Pathways of the River Valley	Home and Community Based Care Provider	A1, A2
Phoenix House	Substance Use Disorder (SUD) Provider	A1, A2, B1
Planned Parenthood of Northern New England - Claremont	Primary Care Practice	A1, A2
Planned Parenthood of Northern New England - Keene	Primary Care Practice	A1, A2
Reality Checks	Other Organization Type	A1, A2
Servicelink-Grafton County	Other Organization Type	A1, A2
Servicelink - Monadnock	Other Organization Type	A1, A2, C1, E5
Southwestern Community Services, Inc.	Community Based Organization Providing Social and Support Services	A1, A2, C1, E5
Stepping Stone & Next Step Respite Centers	Peer Support – Mental Health	A1, A2, E5

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

- 1 We are removing Mascoma Community Health Center from the B1 projects as it has only been operational since mid-Summer 2017 and is currently building their patient base. IDN1 worked to integrate Mascoma Health into the IDN work but the organization has not demonstrated an interest to date. Given the new status of the organization and the many priorities of new health centers the IDN is still working with the organization to determine their role within the IDN long term and specific projects.
2. Please note changes to the B1 attributed organizations relates to the updated 2017 Medicaid Attribution Numbers as those organizations with less than 150 Medicaid members were moved into support roles for B1 led projects.

## Project Scoring: IDN Workforce Process Milestones

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

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

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

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

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

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

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

#### Ongoing IDN HIT Efforts:

Throughout 2018, the Region 1 administrative team focused strategy around project deployment. At the end of Q3 2018, IDN1 revised the HIT project tracking to reflect the project changes. This included the way partners were categorized for HIT projects and subsequent reset of targets:

- HIT Projects were reset based upon Partner categorization.
  - Integrated Partners (4): West Central Behavioral Health, Dartmouth-Hitchcock Heater Road Lebanon, Dartmouth-Hitchcock Psychiatry, and Monadnock Community Hospital
  - Coordinated Care Partners (7): Valley Regional Hospital, Monadnock Family Services, Cheshire Medical Center/Dartmouth-Hitchcock Clinic Keene, Counseling Associates, Alice Peck Day, New London Hospital and Primary Care sites, and Phoenix House
  - Community Support Partners: categorization left unchanged at 9.
  - Hospitals: categorization left unchanged.
- HIT Targets will focus on the following:
  - Integrated Care and Coordinated Care Partners (11 targeted): full technology implementations, including the following: Direct Secure Messaging, Shared Care Planning, Event Notification Service and Quality Reporting where necessary.
  - Community Support Partners: focus on DSM technology for electronic referrals. Some of the Community Support Partners are also working with Shared Care Plans. This requires the completion of a Data Sharing agreement with the IDN for any new Community Support Partner brought on.
  - Hospitals: remain unchanged.

The biggest successes in this reporting period have been firming up engagements with all our Integrated Care and Coordinated Care Partners, and on-boarding all required participants for quality reporting. Technology rollout continues to stay [intentionally] in line with the readiness of our Partner Organizations to engage in care integration projects. The pace of implementation is slow and steady as the projects continue to get off the ground.

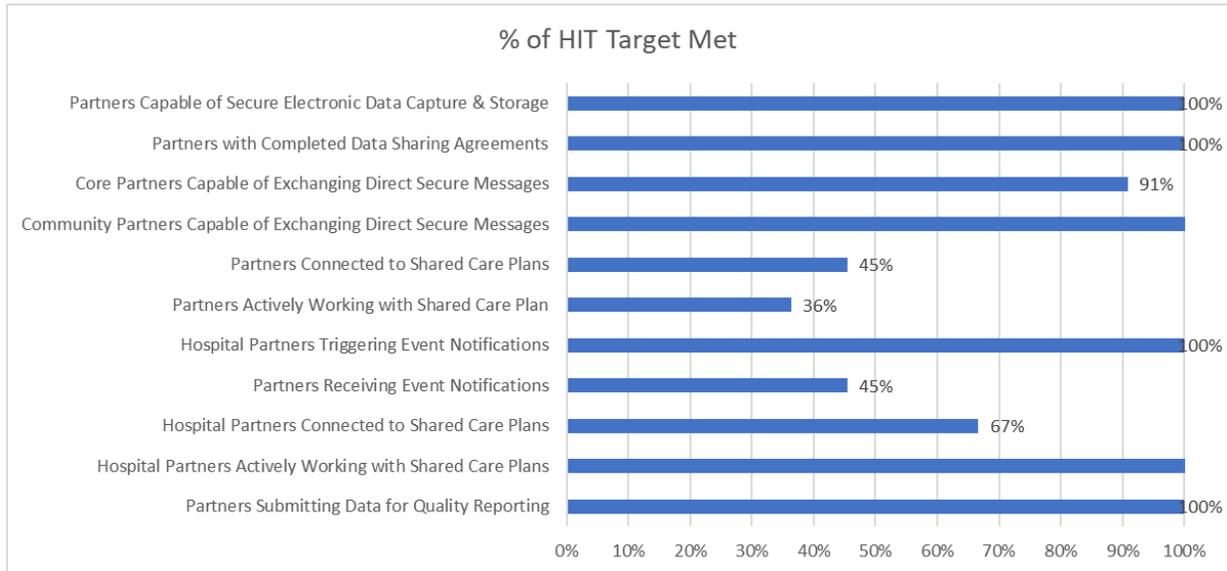
Here are the high points of HIT implementation July – December 2018:

1. Region 1 continued to facilitate contracting among Partner organizations and the technology vendors that require Partner level contracts (CMT, Kno2). During the SAR period the following were updated;
  - a. New contract: CMT and Counseling Associates (in process)
  - b. New QSOA: Phoenix House, Counseling Associates and Headrest
2. Region 1 continues to support new Partners as they onboard around protocols for the Comprehensive Core Standardized Assessment. This includes an ‘out of the box’ list of questions for organizations beginning from scratch with screening. It also includes a process of screening tool review and IDN-1 Medical Director approval for organizations that have existing screening practices in place. Region 1 has conducted webinars to explain to Partners the expectations for CCSA. The Protocol may be found on the IDN-1 website here:  
[http://region1idn.org/resource\\_docs/downloadable/IDN1%20CCSA%20Protocol%20June%202018.pdf](http://region1idn.org/resource_docs/downloadable/IDN1%20CCSA%20Protocol%20June%202018.pdf)
  - a. This document is also embedded into the B1 section of the SAR CCSA Section.
3. Region 1 continues to build on the work done in Q1/Q2 2018 around patient privacy where we established a new data sharing agreement that accommodates both HIPAA and 42 CFR part 2. These agreements were executed with all active projects and are in process with new Partners. We also identified a pathway for SUD treatment patients and their providers to participate in shared care planning. In many cases this requires modification of Partner privacy documentation and forms and we are supporting each Partner to make these changes as they begin shared care planning.
4. We continue to deploy the major technology streams with our Partners as they are ready:
  - a. Direct Secure Messaging: 10 of 11 Integrated Care and Coordinated Care Partners currently have DSM capability. Several Community Support Partners also have the technology in place to support referrals. Any Partner, including those Community Support Partners who lack sufficient EHR capabilities have deployed the Kno-2 secure mailboxes.
  - b. Event Notification Service (via CMT): 4 of the 6 hospitals in the Region are contributing ADT feeds to CMT for event notification (Alice Peck Day, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and Valley Regional Hospital). Additionally, 5 of 11 Integrated Care and Coordinated Care Partners are receiving event notifications (West Central Behavioral Health, D-H Heater Road, D-H Dept. of Psychiatry, Valley Regional Hospital/Primary Care, Cheshire Medical Center. 1 Community Support Partner is current receiving event notification (Crotched Mountain).
  - c. Pre-Manage ED (via CMT): The ED alerting technology, Pre-Manage ED, is live with 3 of the 6 hospitals in the region (Mary Hitchcock Memorial Hospital, Cheshire Medical Center, and Valley Regional Hospital).
  - d. Shared Care Plan (via CMT): The shared care planning and community provider alerting technology, Pre-Manage Community, is live with 5 of 11 Integrated Care and Coordinated Care Partners.
  - e. Quality Reporting (via Massachusetts eHealth Collaborative Quality Data Center): All 11 Integrated Care and Coordinated Care Partners, including hospital affiliates are now actively engaged with the quality reporting service.
5. The Region 1 Data & IT Work Group met monthly, highlighting HIT progress, quality reporting updates and providing a platform for members to share stories and ask questions

6. 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, 2018.

*Figure 1: Region 1 Progress Relative to HIT Targets as of December 31, 2018*



The focus of HIT implementation efforts this year has been the Integrated Care and Coordinated Care Partners of the projects with a new wave of projects that deployed in the fall and early winter of 2018. Region 1 HIT deployment is in tandem with project deployment. Each project team has defined process changes, updated patient privacy policies and processes, defined new roles to hire and train, and moved to implementation. The IT components supporting implementation are:

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

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

The following dashboard shows the HIT implementation progress to date. New for this year, the HIT Dashboard has been refocused on IDN-1's Integrated Care Partners and Coordinated Care Partners.

Additionally, Community Care Partners may be brought in to provide a vital wrap-around service. Green indicates that the HIT capability is fully in place. Yellow indicates that contracting and implementation are in progress. Red indicates that the capability is not in place and contracting and implementation have not yet started. Measurement targets are included at the bottom.

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

Organization	Electronic Data Capture & Secured Data Storage	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications	Submitting Quality Data
<b>Integrated Care Partners</b>							
West Central Behavioral Health	Green	Green	Green	Green	Green	Green	Green
Dartmouth-Hitchcock Lebanon	Green	Green	Green	Green	Green	Green	Green
Dartmouth-Hitchcock Psychiatry	Green	Green	Green	Green	Green	Green	Green
Monadnock Community Hospital	Green	Green	Green	Red	Red	Red	Green
<b>Coordinated Care Partners</b>							
Valley Regional Hospital	Green	Green	Green	Green	Green	Green	Green
Monadnock Family Services	Green	Green	Green	Yellow	Yellow	Yellow	Yellow
Cheshire Medical Center / DH Clinic Keene	Green	Green	Green	Green	Green	Green	Green
Counseling Associates	Green	Green	Green	Green	Green	Green	Green
Alice Peck Day	Green	Green	Green	Red	Red	Red	Green
New London Hospital / Newport Health Center Practice	Green	Green	Green	Red	Red	Red	Green
Phoenix House	Green	Red	Green	Red	Red	Red	Green
<b>Total</b>	<b>11</b>	<b>10</b>	<b>11</b>	<b>5</b>	<b>4</b>	<b>5</b>	<b>11</b>
<b>Target</b>	<b>11</b>	<b>11</b>	<b>11</b>	<b>11</b>	<b>11</b>	<b>11</b>	<b>11</b>
<b>% of Total</b>	<b>100%</b>	<b>91%</b>	<b>100%</b>	<b>45%</b>	<b>36%</b>	<b>45%</b>	<b>100%</b>

Organization	Capable of Direct Secure Messaging	Data Sharing Agreement	Connected to Shared Care Plan	Actively Using Shared Care Plan	Receiving Event Notifications
<b>Community Support Partners</b>					
Crotched Mountain Community Care	Green	Green	Green	Green	Green
Granite State Independent Living (GSIL)	Red	Red	Red	Red	Red
Headrest	Red	Green	Yellow	Red	Red
MAPS	Red	Red	Red	Red	Red
Monadnock Collaborative (Claremont)	Green	Red	Red	Red	Red
Monadnock Collaborative (Keene)	Green	Red	Red	Red	Red
New Hampshire Hospital	Yellow	Red	Red	Red	Red
TLC Family Resource Center	Green	Green	Red	Red	Red
Visiting Nurse & Hospice of VT/NH	Green	Red	Red	Red	Red
<b>Total</b>	<b>10</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>1</b>
<b>Target</b>	<b>9</b>	<b>9</b>	<b>9</b>	<b>9</b>	<b>9</b>
<b>% of Total</b>	<b>111%</b>	<b>33%</b>	<b>11%</b>	<b>11%</b>	<b>11%</b>

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	Green	Red	Red
Cheshire Medical Center	Green	Green	Green
Dartmouth Hitchcock Medical Center	Green	Green	Green
Monadnock Community Hospital	Red	Red	Red
New London Hospital	Yellow	Red	Red
Valley Regional Hospital	Green	Green	Green
<b>Total</b>	<b>4</b>	<b>3</b>	<b>3</b>
<b>Target</b>	<b>4</b>	<b>3</b>	<b>2</b>
<b>% of Total</b>	<b>100%</b>	<b>100%</b>	<b>150%</b>

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

## Work Stream 1: Support Partners in Waves

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

Deliverable/Milestone	Jan-Jun '17	Jul '17	Aug	Sep	Oct	Nov	Dec	Jan '18	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Status	Milestone Reporting Pd	
<b>Work Stream 1: Support Partners in Waves</b>																					12/31/2018	
<b>Identify Partners to Support with HIT - Wave 1</b>																					Completed	12/31/2017
Conduct RFA Process to consider, vet, and select wave 1 projects																					Completed	6/30/2017
Identify Wave 1 Core Partners and Potential Supporting Partners																					Completed	6/30/2017
<b>Milestone: List of Integrated Care, Coordinated Care, and Community Supports</b>																					Completed	6/30/2017
Conduct second RFA Process to solicit additional B1 Projects																					Completed	12/31/2017
Update Wave 1 Core Partners and Potential Supporting Partners																					Completed	12/31/2017
<b>Milestone: List of Integrated Care, Coordinated Care, and Community Supports</b>																					Completed	12/31/2017
<b>Identify Partners to Support with HIT - Wave 2</b>																					Completed	6/30/2018
Conduct RFA Process to consider, vet, and select wave 2 projects																					Completed	6/30/2018
Identify Wave 2 Core Partners and Potential Supporting Partners																					Completed	6/30/2018
<b>Milestone: List of Integrated Care, Coordinated Care, and Community Supports</b>																					Completed	6/30/2018
<b>Identify and Recruit Remaining Partners to Support with HIT</b>																					Completed	12/31/2018
Identify remaining Partners to support with HIT																					Completed	12/31/2018
Recruit and contract with remaining partners (with IDN admin team)																					Completed	12/31/2018
<b>Milestone: List of Integrated Care, Coordinated Care, and Community Supports</b>																					Completed	12/31/2018

### Accomplishments:

- Region 1 successfully engaged all targeted Integrated Care and Coordinated Care Partners by the close of Q418. Deployment of HIT services is in tandem with program deployment by the Partner organizations.

**Adjustments to Plan:** None

**Upcoming Activity:** Under new Partner categorizations, we will focus efforts on supporting any new Community Support Partners as needed.

## 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 Report	
Work Stream 2: Engage Vendors																					12/31/2018	
Complete vendor selection to support IT investments																					Completed	12/31/2017
Milestone: Select vendor for Technical Support																					Completed	6/30/2017
Milestone: Select vendor(s) for shared care plan, Pre-Manage ED, and ENS																					Completed	6/30/2017
Milestone: Select vendor for Direct Secure Messaging Webmail																					Completed	6/30/2017
Milestone: Select vendor for Data Extraction, Validation, and Quality Reporting																					Completed	12/31/2017
Execute contract for Technical Support - Massachusetts eHealth Collaborative																					Completed	6/30/2017
Develop contracts with Vendor and Legal																					Completed	6/30/2017
Milestone: Agreement executed between MAeHC and IDN-1																					Completed	6/30/2017
Execute contracts for Pre-Manage ED / ENS - Collective Medical Technology																					In Progress	6/30/2019
Develop contracts with Vendor and Legal																					Completed	6/30/2017
Milestone: Agreement executed between CMT and IDN-1																					Completed	12/31/2017
Facilitate CMT Agreements with Partner Hospitals																					In Progress	12/31/2018
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																					Deferred	6/30/2019
Milestone: Agreement executed between CMT and Alice Peck Day																					Deferred	6/30/2019
Milestone: Agreement executed between CMT and Monadnock Community Hospital																					Deferred	6/30/2019
Facilitate CMT Agreements with Partners																					In Progress	6/30/2019
Milestone: Agreement executed between CMT and WCBH																					Completed	12/31/2017
Milestone: Agreement executed between CMT and DH Lebanon																					Completed	6/30/2017
Milestone: Agreement executed between CMT and DH Psychiatry																					Completed	6/30/2017
Milestone: Agreement executed between CMT and Monadnock Community Hospital																					Deferred	6/30/2019
Milestone: Agreement executed between CMT and Valley Regional																					Completed	12/31/2017
Milestone: Agreement executed between CMT and MFS																					Completed	12/31/2017
Milestone: Agreement executed between CMT and Cheshire Medical Center / DH Keene																					Completed	12/31/2017
Milestone: Agreement executed between CMT and Counseling Associates																					Completed	12/31/2018
Milestone: Agreement executed between CMT and APD																					Deferred	6/30/2019
Milestone: Agreement executed between CMT and New London Hospital																					Deferred	6/30/2019
Milestone: Agreement executed between CMT and Phoenix House																					Deferred	6/30/2019
Milestone: Agreement executed between CMT and Crotched Mountain																					Completed	12/31/2017
Milestone: Agreement executed between CMT and Monadnock Collaborative																					Completed	6/30/2018
Milestone: Agreement executed between CMT and New Hampshire Hospital																					Deferred	6/30/2019
Execute contracts - Kno-2																					Completed	9/30/2018
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 Kno-2 Agreements with Partners																					Completed	9/30/2018
Milestone: Agreement executed between Kno-2 and WCBH																					Completed	12/31/2017
Milestone: Agreement executed between Kno-2 and MFS																					Completed	12/31/2018
Milestone: Agreement executed between Kno-2 and Monadnock Collaborative																					Completed	12/31/2017
Milestone: Agreement executed between Kno-2 and GSIL																					Completed	12/31/2017
Milestone: Agreement executed between Kno-2 and Crotched Mountain																					Completed	12/31/2017
Milestone: Agreement executed between Kno-2 and TLC Family Resource Center																					Completed	6/30/2018
Milestone: Agreement executed between Kno-2 and Counseling Associates																					Completed	9/30/2018
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.
- Contracting between the shared care plan and ENS vendor (Collective Medical) and the Direct Secure Messaging vendor (Kno-2) has been facilitated as each project is ready to support shared care planning and communications with technology.
- CMT contracting process begun with Counseling Associates.
- QSOAs and BAAs for Quality Reporting were executed with Monadnock Community Hospital, New London Hospital, Inc., Phoenix House and Counseling Associates

**Adjustments to Plan:** Region 1 participation/engagement and vendor contracting with Partner organizations continues to take a significant amount time and effort, due in part to lack of leadership and accountability and complex contract review. CMT agreements with New London Hospital, Alice Peck Day, Monadnock Community Hospital, New Hampshire Hospital and Phoenix House activities are deferred to SAR June 20, 2019 while Region 1 continues to strengthen relationships and projects get up off the ground.

**Upcoming Activity:** Under the new Partner categorization, the following contracts are outstanding and will be the focus for the next reporting period (Jan – Jun 2019):

- CMT contracts
  1. Integrated Care and Coordinated Care Partners: Monadnock Community Hospital, Alice Peck Day, New London Hospital, and Phoenix House
  2. Community Support Partners: Headrest, Monadnock Collaborative

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

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

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

**Accomplishments:**

- Completed workflows for the following: Inter-Core Team Referral, Referral to Supports, Event Notification. Workflows are available on Region 1 website under B1 Protocols.

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

**Upcoming Activity:** The priority for the next period is to replicate and scale the design work that has been completed to date. The CCSA protocol will be expanded to include adolescents.

## Work Stream 4: Ensure Patient Privacy

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

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

**Accomplishments:**

- IDN-1 provided Privacy Training to Valley Regional Hospital and Headrest.
- IND-1 executed Data Sharing Agreements with the following Partners: Monadnock Community Hospital, Monadnock Family Services, Counseling Associates, New London Hospital Association, Phoenix House and Headrest.
- IDN-1 obtained newly executed copies of the QSOA, including an updated BAA with Crotched Mountain and TLC Family Resources.

**Adjustments to Plan:** None

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

## Work Stream 5: Roll Out Shared Technology with Partners

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

Deliverable/Milestone	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 Report	
<b>Work Stream 5: Roll Out Shared Technology with Partners</b>																						12/31/2018
<b>Deploy Pre-Managed ED Across Region</b>																					In Progress	9/30/2018
Deploy Pre-Managed ED (ADT Feed)																					In Progress	6/30/2019
Milestone: Mary Hitchcock Sending ADT Feed to CMT																					Completed	12/31/2017
Milestone: Cheshire Medical Center Sending ADT Feed to CMT																					Completed	12/31/2017
Milestone: Valley Regional Sending ADT Feed to CMT																					Completed	12/31/2017
Milestone: New London Hospital Sending ADT Feed to CMT																					Deferred	6/30/2019
Milestone: Monadnock Community Hospital Sending ADT Feed to CMT																					Deferred	6/30/2019
Milestone: Alice Peck Day Sending ADT Feed to CMT																					Completed	12/31/2018
Deploy / Train Pre-Managed ED - ED Team Application																					In Progress	12/31/2018
Milestone: Pre-manage ED in use with Mary Hitchcock																					Completed	12/31/2017
Milestone: Pre-manage ED in use with Valley Regional																					Completed	6/30/2018
Milestone: Pre-manage ED in use with Cheshire																					Deferred	12/31/2018
Milestone: Pre-manage ED in use with New London Hospital																					Deferred	6/30/2019
Milestone: Pre-manage ED in use with Monadnock Community Hospital																					Deferred	6/30/2019
Milestone: Pre-manage ED in use with Alice Peck Day																					Deferred	6/30/2019
<b>Deploy Technical Assistance to IDN-1 Partners</b>																					Completed	12/31/2018
Deploy Technical Assistance to IDN-1 Partners																					Completed	9/30/2018
<b>Deploy Pre-Managed Community to Integrated Care and Coordinated Care Partners</b>																					In Progress	6/30/2019
Milestone: Pre-manage Community Connected with WCBH																					Completed	9/30/2018
Milestone: Pre-manage Community Connected with DH Lebanon																					Completed	6/30/2018
Milestone: Pre-manage Community Connected with DH Psychiatry																					Completed	6/30/2018
Milestone: Pre-manage Community Connected with Monadnock Community Hospital																					Deferred	6/30/2019
Milestone: Pre-manage Community Connected with Valley Regional																					Completed	12/31/2018
Milestone: Pre-manage Community Connected with MFS																					Deferred	6/30/2019
Milestone: Pre-manage Community Connected with Cheshire																					Deferred	6/30/2019
Milestone: Pre-manage Community Connected with Counseling Associates																					Deferred	6/30/2019
Milestone: Pre-manage Community Connected with APD																					Deferred	6/30/2019
Milestone: Pre-manage Community Connected with NLH																					Deferred	6/30/2019
Milestone: Pre-manage Community Connected with Phoenix House																					Deferred	6/30/2019
<b>Deploy Pre-Managed Community to Community Support Partners</b>																					In Progress	6/30/2019
Milestone: Pre-manage Community Connected with Crotched Mt																					Completed	6/30/2018
<b>Deploy Direct Messaging to Integrated Care and Coordinated Care Partners</b>																					In Progress	6/30/2019
Milestone: DSM enabled with WCBH																					Completed	12/31/2017
Milestone: DSM enabled with DH Lebanon																					Completed	6/30/2017

Milestone: DSM enabled with DH Psychiatry																		Completed	6/30/2017
Milestone: DSM enabled with Monadnock Community Hospital																		Completed	6/30/2017
Milestone: DSM enabled with Valley Regional																		Completed	6/30/2017
Milestone: DSM enabled with MFS																		Completed	12/30/2018
Milestone: DSM enabled with Cheshire Medical Center																		Completed	6/30/2017
Milestone: DSM enabled with Counseling Associates																		Completed	12/30/2018
Milestone: DSM enabled with APD																		Completed	6/30/2017
Milestone: DSM enabled with NLH																		Completed	6/30/2017
Milestone: DSM enabled with Phoenix House																		Deferred	6/30/2019
Deploy Direct Messaging to Community Supports Partners																		Completed	12/30/2018
Milestone: DSM enabled with Crotched Mt																		Completed	6/30/2018
Milestone: DSM enabled with GSIL																		Completed	6/30/2018
Milestone: DSM enabled with Monadnock Collaborative																		Completed	12/31/2017
Milestone: DSM enabled with TLC Family Resource Center																		Completed	6/30/2018
Deploy Quality Reporting Service (QRS) with Integrated Care and Coordinated Care Partners																		Completed	12/31/2018
Milestone: QRS enabled with WCBH																		Completed	3/31/2018
Milestone: QRS enabled with DH Lebanon																		Completed	3/31/2018
Milestone: QRS enabled with DH Psychiatry																		Completed	3/31/2018
Milestone: QRS enabled with Monadnock Community Hospital																		Completed	12/31/2018
Milestone: QRS enabled with Valley Regional																		Completed	3/31/2018
Milestone: QRS enabled with MFS																		Completed	9/30/2018
Milestone: QRS enabled with Cheshire Medical Center																		Completed	3/31/2018
Milestone: QRS enabled with Counseling Associates																		Completed	12/31/2018
Milestone: QRS enabled with APD																		Completed	3/31/2018
Milestone: QRS enabled with NLH																		Completed	3/31/2018
Milestone: QRS enabled with Phoenix House																		Completed	12/31/2018
Train and provide technical support to Partners																		Completed	12/31/2018



**Upcoming Activity:**

- IDN will focus on the remaining gaps in the project plan with onboarding of our newer B1 Project partners, New London Hospital, Monadnock Community Hospital, Alice Peck Day, Counseling Associates, and Phoenix House.
- Shared Care Plan technology is being rolled out with each integrated care project when ready.
- Direct Messaging is to be deployed with Phoenix House and with Community Supports organizations that are receiving information from Partners.
- Continue to train and support all Partners

## Work Stream 6: Preparing for Shift to Value Based Payment

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

Deliverable/Milestone	Jan '19	Feb	Mar	Apr	May	Jun	Jul '18	Aug	Sep	Oct	Nov	Dec	Jan '20	Feb	Mar	Apr	May	Jun	Status	Milestone Reporting	
<b>Work Stream 6: Preparing for Shift to Value Based Payment</b>																				12/31/2018	
<b>Support Planning for Shift to Value Based Payment</b>																				Pending	6/30/2019
Inform Payment Model Discussions with HIT Expertise																				Pending	6/30/2019
Adjust HIT Service Offering to Meet Evolving VBP Requirements																				Pending	6/30/2019
<b>Provide Ongoing Support to Partners</b>																				Pending	6/30/2019
Provide Ongoing Technology Coordination Support to Partners																				Pending	6/30/2019
Coordinate with Vendor technical support teams to support partners																				Pending	6/30/2019
<b>Assess HIT Technical Supports Needs</b>																				Pending	6/30/2019
Assess HIT Technical Supports relative to Project Requirements																				Pending	6/30/2019
Assess Desired and Optional Requirements Market Readiness																				Pending	6/30/2019
Assess New Requirements Stemming from VBP Discussions																				Pending	6/30/2019
<b>Adjust HIT Service Offering</b>																				Pending	6/30/2019
Adjust HIT Service Offering																				Pending	6/30/2019
Provide Technical Assistance based on HIT Service Offering																				Pending	6/30/2019
<b>Work with MCOs to Maximize Value of Data Assets for Medicaid Members (optional)</b>																				Pending	6/30/2019
Determine role of MCO in IDN Work																				Pending	6/30/2019
Determine MCO data assets that may benefit IDN																				Pending	6/30/2019
Determine Means for Sharing Information among MCOs and IDN																				Pending	6/30/2019

### Accomplishments:

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

**Adjustments to Plan:** No adjustments.

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

Note: Workstream 6 is anticipated to begin in 2019 and is reliant upon statewide guidance regarding the APM roadmap and related discussions and plans. Until further guidance is received from DHHS, all activities have been deferred.

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

### Accomplishments:

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

**Adjustments to Plan:** No Adjustments.

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

### A2-4. IDN HIT: Evaluation Project Targets

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Integrated Care and Coordinated Care Partners Connected to Shared Care Plans	11	2	3	5
# Integrated Care and Coordinated Care Partners Actively Working with Shared Care Plans	11	0	2	4
# Integrated Care and Coordinated Care Partners Receiving Event Notifications	11	0	3	6
# of Integrated Care and Coordinated Care Partners Submitting Data for Quality Reporting (data feed and/or portal)	11	0	7	11

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of Integrated Care and Coordinated Care Partners Capable of exchanging Direct Messages	11	13	12	10
# of Community Support Partners Capable of exchanging Direct Messages	9	6	6	10
# Hospital Partners Sending ADT Messages to ENS	4	3	3	4
# Hospital Partners Connected to Pre-Manage ED	4	1	2	2
# Hospital Partners Actively Working with Pre-Manage ED	4	0	1	2

Note: As part of the December 2018 Semi-Annual Report submission, IDN-1 adjusted the target number of organizations above based on categorization of partners.

Additional Note: For the December 2018 Semi-Annual Report submission IDN-1 adjusted the target number of organizations to submit quality data from 13 to 11, based on the categorization of partners.

1. Alice Peck Day Memorial Hospital and Primary Care
2. Cheshire Medical Center (DH Keene) and Primary Care
3. Counseling Associates
4. Dartmouth Hitchcock Medical Center and Primary Care
5. Dartmouth Hitchcock Department of Psychiatry
6. Monadnock Community Hospital - Primary Care
7. New London Medical Group Practice and New London Hospital
8. New London Pediatric Care Center Practice
9. Newport Health Center Practice
10. Phoenix House
11. Valley Regional Hospital and Primary Care

**IDN-1 Progress with Statewide HIT Work Group Minimum Requirements**

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

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

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

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

**Minimum Requirement – Direct Secure Messaging: Most (10 of 11) Coordinated and Integrated Care Partners meet this requirement. Phoenix House does not yet meet this requirement. Phoenix House began active project engagement with IDN-1 in late fall of 2018 and prioritized the quality reporting project for 2018 and Direct Secure Messaging (DSM) for 2019. IDN-1 will work with Phoenix House to implement Webmail-based DSM by June 30, 2019.**

**Minimum Requirement – Shared Care Plan: ~Half of (5 of 11) Coordinated and Integrated Care Partners meet this requirement. Monadnock Community Hospital, Monadnock Family Services, Counseling Associates, Alice Peck Day, New London Hospital, and Phoenix House do not yet meet this requirement. All 6 Partners are working toward implementing Multi-Disciplinary Core Team (MDCT) programs as part of their contracts with IDN-1. 3 Partners; Counseling Associates, Phoenix House, and Alice Peck Day, are working toward implementing Event Notification in concert with shared care plan technology by June 30, 2019. Monadnock Community Hospital and New London Hospital are not yet engaging with the event notification/shared care plan vendor despite over 2 years of discussions among the Partners and IDN-1 leaders. We recognize significant risk that these partners will not engage but will continue to pursue these Partners through Dec 31, 2019.**

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

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

**Minimum Requirement – Event Notification: Half (6 of 11) Coordinated and Integrated Care Partners meet the requirement for receiving event notifications. 4 of 6 Hospitals are sending events to the event notification service. Monadnock Community Hospital, Counseling Associates, Alice Peck Day, New London Hospital, and Phoenix House are not yet receiving event notifications. 3 Partners; Counseling Associates, Phoenix House, and Alice Peck Day, are working toward implementing Event Notification in concert with shared care plan technology by June 30, 2019. Monadnock Community Hospital and New London Hospital are not yet engaging with the event notification/shared care plan vendor despite over 2 years of discussions among the Partners and IDN-1 leaders. We recognize significant risk that these partners will not engage but will continue to pursue these Partners through Dec 31, 2019.**

## A2-5. IDN HIT: Workforce Staffing

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

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

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

**A2-6. IDN HIT: Budget**

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

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

The Consultant costs cover the following:

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

The Software costs cover the following:

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

Overview Budgets for IDN1 HIT:

**REDACTED TABLE**

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

*Figure 4: IDN-1 IT Solutions Budget*

**REDACTED TABLE**

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

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

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

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

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

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

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

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

## A2-8. IDN HIT. Data Agreement

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

Organization Name	Data Sharing Agreement Signed Y/N
Alice Peck Day Primary Care	Y
Counseling Associates	Y
Crotched Mountain Community Care	Y
Dartmouth-Hitchcock Clinic Lebanon	Y
Dartmouth Hitchcock Keene (Cheshire Medical Center)	Y
Dartmouth-Hitchcock Psychiatry	Y
Headrest	Y
Monadnock Community Hospital - Primary Care	Y
Monadnock Family Services	Y
New London Medical Group Practice	Y
New London Pediatric Care Center Practice	Y
Newport Health Center Practice	Y
Phoenix House	Y

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

Please note the following indicates:

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

## Project Scoring: IDN HIT Process Milestones

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

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

## Project B1: Integrated Healthcare

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

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

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

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

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

*The Coordinated Care Practice must include:*

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

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

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

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

### B1 RFP and Implementation Waves

#### Overview of the IDN1 Process: No Change July-December, 2018

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

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

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

During the July- December, 2018 term there have been no additional releases of B1 RFP's and the IDN admin team will not be looking to initiate new B1 projects in CY2019. The IDN team is using its resources and staff time in B1 projects to focus on spread and scale of the organizations involved to date.

## **B1 Dartmouth-Hitchcock Heater Rd. South Practices /West Central Behavioral Health Integrated Care Project Updates (Addressing coordination between providers, bi-directional integrated delivery, behavioral health services, alignment of care**

*See appendix B1-2: DH HRS/WCBH for updated Workplan (Jul-Dec, 2018)*

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

## Current State: July 1, 2018-December 31, 2018

### Project Workflows and Team Development:

As of 12/31/18 the DH- Heater Rd. S. /WCBH project team is fully staffed with 1 FTE CTC, 1 FTE CHW, and .5 BHC for the full Heater Rd. S. practice (S1, S2, S3 teams).

- The DH-HRS/WCBH B1 Team continues to meet on a biweekly schedule with the support of the IDN Program Director, Medical Director and QI Coaching for facilitation and quality improvement guidance.
  - Given the progress made in the July-December term the HRS/WCBH team will be scaling back to 1x monthly facilitated project meetings as they continue to meet clinical milestones and implement short cycle PDSA's as needed
- The CTC is located at WCBH 1 day weekly and participates in team meetings when possible. This fosters a closer coordination with the WCBH staff and inclusion in the ongoing project development.
  - The CTC has continued to strengthen relationships with WCBH clinicians, team leads and data staff
    - This coordination has greatly improved the ease of implementation and outcomes the team has seen.
- As of late February, 2018 the CTC supervises an AmeriCorps funded CHW, who is a person in recovery, who leads support sessions at WCBH for Medicaid patients. Additionally, the CHW attends all of the project team meetings and shares his perspective as a consumer of services. The team has found his input to be valuable and a resource to the team. There has been no change to the engagement of the CHW.
  - The AmeriCorps member's date of Year 1 completion is February 10, 2019.
- Use of patient registry and identification fields. As the pool of identified MDCT eligible patient grows and the team comes to scale on implementation they are undertaking expanded registry development. As well as reviewing ED high utilization, DH Inpatient reports.
- Ongoing coordination with other IDN projects and external project work within DH-HRS. The CTC takes the lead on the coordination and participates in ongoing DH system wide meetings. Additionally, the use of the SCP prompts an immediate flag on the EPIC patient screen which triggers a clinician looking at the record to see the IDN involvement. This can also be triggered by looking at the Care Team providers where the CTC is listed.
- The project team is working to define their Year 2-3 milestones for quarterly review and progress tracking. The evaluation format used in Year 1 will continue with a template format and standardized submission dates.
- Ongoing efforts have been made to share project information to the B1 population being seen at HRS and WCBH. This effort commenced with a letter out to community support partners and has continued with the below flyer being used for patient education. See below: *No change to patient infographic in July- December, 2018 term.*
  - The CTC is working on an updated form of the infographic that is not specific to any Primary Care practice within the DH health system so it can also be used by GIM staff.

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**Your Shared Care Plan**

The graphic features two overlapping circles: a dark blue circle on the left labeled "Primary Care Team" and a yellow circle on the right labeled "Behavioral Health Team". A white line with a dot at the top and bottom connects the two circles at their intersection. Below the circles, the text "D-H Heater Road Primary Care" is aligned with the dark blue circle, and "West Central Behavioral Health" is aligned with the yellow circle.

**Primary Care Team**  
D-H Heater Road  
Primary Care

**Behavioral Health Team**  
West Central  
Behavioral Health

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

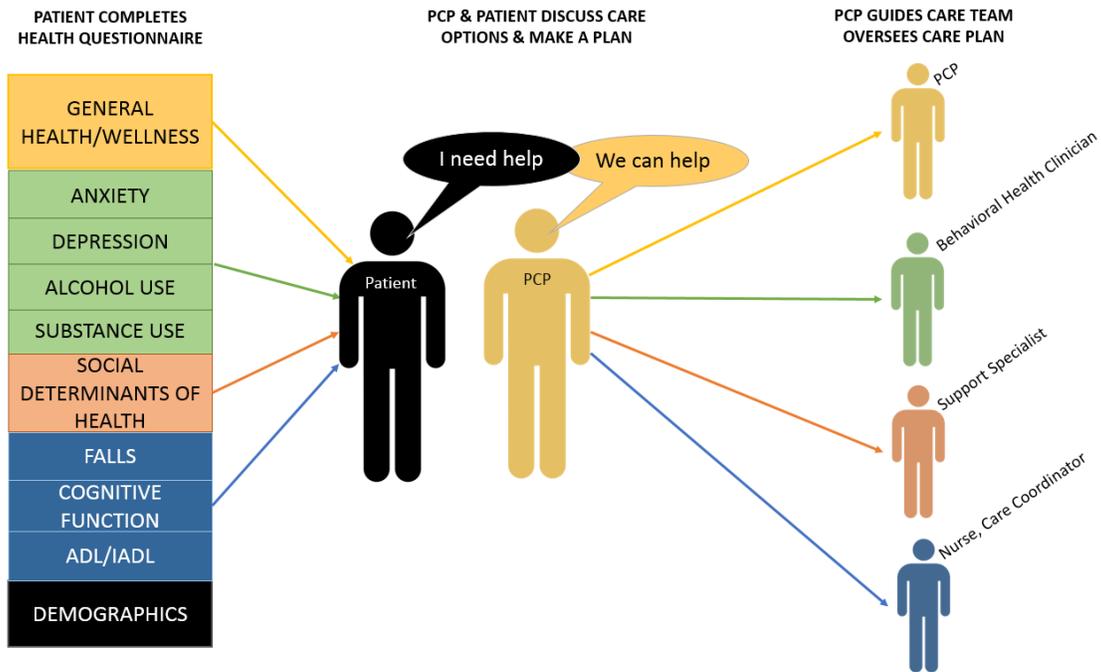
 

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- Ongoing data collection continues on # of CCSA's and the domain analytics on response trends, high acuity SDoH areas etc.
  - The IDN team with the clinical team and internal QI resources are continually reviewing for response trends, high need areas and to bolster community support relationships as appropriate.

- The team continues to work to strengthen their closed loop referral processes and clinical protocols
  - See IDN1 Protocol Guidelines attached below.
- The team has continued to meet all quarterly milestones and growth targets.
- Additional materials have been created across the DH Primary Care Teams at Heater Road and other sites to respond the EPIC embedded CCSA. See below:



.CCCSA populates responses in progress note; PCP reviews for positive results and discusses care options with patient

myDH Primary Care	7/19/2018	
PROMIS 10-Health in general	Good	
PROMIS 10-Quality of life	Fair	
PROMIS 10-Physical health	Poor	
PROMIS 10-Mental health	Fair	
PROMIS 10-Satisfaction with social activities	Fair	
PROMIS 10-Ability to carry out social activities	Good	
PROMIS 10-Ability to carry out physical activities	Fair	
PROMIS 10-Bothered by emotional problems	Sometimes	
PROMIS 10-Rate of fatigue	Moderate	
PROMIS 10-Rate of pain	5	
PROMIS 10-Physical Health Score	32.4	
PROMIS 10-Mental Health Score	36.3	
SDoH - Housing	7/19/2018	
What is your housing situation today?	I have housing today, but I am worried about losing housing in the next 90 days	
Think about the place you live. Do you have problems with any of the following?	None of the above	
SDoH - Financial Strain	7/19/2018	
How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?	Somewhat hard	
What do you have trouble paying for?	Food, Utility bills (electric, etc.), Debts	
SDoH - Education	7/19/2018	
Do you ever need help reading health related materials?	Yes	
SDoH - Social Isolation	7/19/2018	
Do you have someone you could call if you need help?	Yes	
SDoH - Transportation	7/19/2018	
In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need	
SDoH - Employment	7/19/2018	
What was your main activity during most of the last 12 months?	Worked for pay	
SDoH - Interpersonal Safety	7/19/2018	
In the last 12 months, are you or have you been threatened or abused physically, emotionally or sexually by a partner, spouse or family member?	Yes	
SDoH - Legal	7/19/2018	
Do you have any legal issues that are getting in the way of your health or healthcare?	No	
How confident are you that you can control and manage your situation?	Not very confident; I would like information about resources that will help me control and manage my situation	
Behavioral Health Responses	7/19/2018	
PHQ-2 Score	4 (Full PHQ-9 indicated)	
Total PHQ-9	11 (Moderate Depression)	
GAD-2 Score	3 (Full GAD-7 indicated)	
Total GAD-7	10 (Moderate Anxiety)	
Audit Screener	Yes	
Audit Final Scores	14 (At Risk)	
Drug Screener	Yes	
DAST10 Score	2 (Low Level)	
PC Q - ADL/IADL/FALL	7/19/2018	
Activity - low level (Bathing, Dressing, Eating, Mobility, Using toilet, Grooming)	Bathing, Getting in or out of chairs	
ADL Help	I could use a little more help	
Activity - high level (Laundry, Housekeeping, Banking, Shopping, Use phone, Food Prep, Transportation, Taking meds)	Doing laundry and housekeeping, Banking, Food preparation	
IADL Help	I could use a little more help	
Fallen in last year	No	
Difficulties with balance or walking	Yes	

SDoH - Housing	7/19/2018	
What is your housing situation today?	I have housing today, but I am worried about losing housing in the next 90 days	
Think about the place you live. Do you have problems with any of the following?	None of the above	
SDoH - Financial Strain	7/19/2018	
How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?	Somewhat hard	
What do you have trouble paying for?	Food, Utility bills (electric, etc.), Debts	
SDoH - Education	7/19/2018	
Do you ever need help reading health related materials?	Yes	
SDoH - Social Isolation	7/19/2018	
Do you have someone you could call if you need help?	Yes	
SDoH - Transportation	7/19/2018	
In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need	
SDoH - Employment	7/19/2018	
What was your main activity during most of the last 12 months?	Worked for pay	
SDoH - Interpersonal Safety	7/19/2018	
In the last 12 months, are you or have you been threatened or abused physically, emotionally or sexually by a partner, spouse or family member?	Yes	
SDoH - Legal	7/19/2018	
Do you have any legal issues that are getting in the way of your health or healthcare?	No	
How confident are you that you can control and manage your situation?	Not very confident; I would like information about resources that will help me control and manage my situation	
Behavioral Health Responses	7/19/2018	
PHQ-2 Score	4 (Full PHQ-9 indicated)	
Total PHQ-9	11 (Moderate Depression)	
GAD-2 Score	3 (Full GAD-7 indicated)	
Total GAD-7	10 (Moderate Anxiety)	
Audit Screener	Yes	
Audit Final Scores	14 (At Risk)	
Drug Screener	Yes	
DAST10 Score	2 (Low Level)	
PC Q - ADL/IADL/FALL	7/19/2018	
Activity - low level (Bathing, Dressing, Eating, Mobility, Using toilet, Grooming)	Bathing, Getting in or out of chairs	
ADL Help	I could use a little more help	
Activity - high level (Laundry, Housekeeping, Banking, Shopping, Use phone, Food Prep, Transportation, Taking meds)	Doing laundry and housekeeping, Banking, Food preparation	
IADL Help	I could use a little more help	
Fallen in last year	No	
Difficulties with balance or walking	Yes	

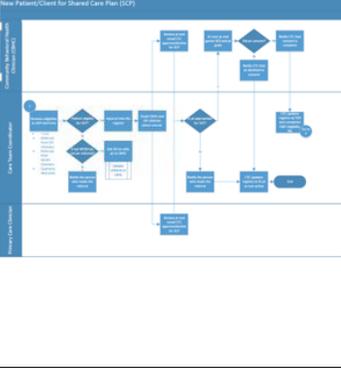
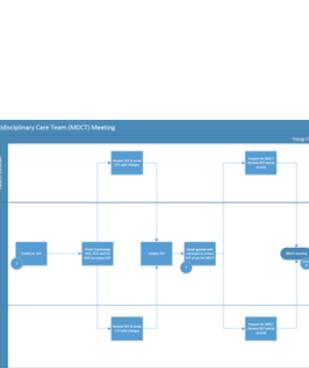
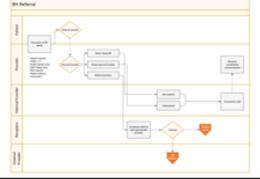
- CCSA results indicate further assessment is needed.
- PCP discusses care options with patient.
- PCP engages members of the care team for follow-up in concordance with patient's wishes.

1. Screening results are positive for social determinant(s) of health (SDoH) and patient is requesting help (flows to RWB)

2. Screening results are positive for behavioral health; Brief Intervention (SBIRT) recommended; Refer to Treatment w/BHC (REF219) <https://www.integration.samhsa.gov/clinical-practice/sbirt/training-other-resources>

3. Screening results are positive for falls, cognitive function and/or assistance with ADL/IADL (engage Nurse, Nurse CC, VNH)

- See updated team A3 below. As the IDN1 team with support from the QI coaches continues to move projects along the continuum we are introducing new QI tools and standardized processes to help sustain the work as project facilitation scales back;

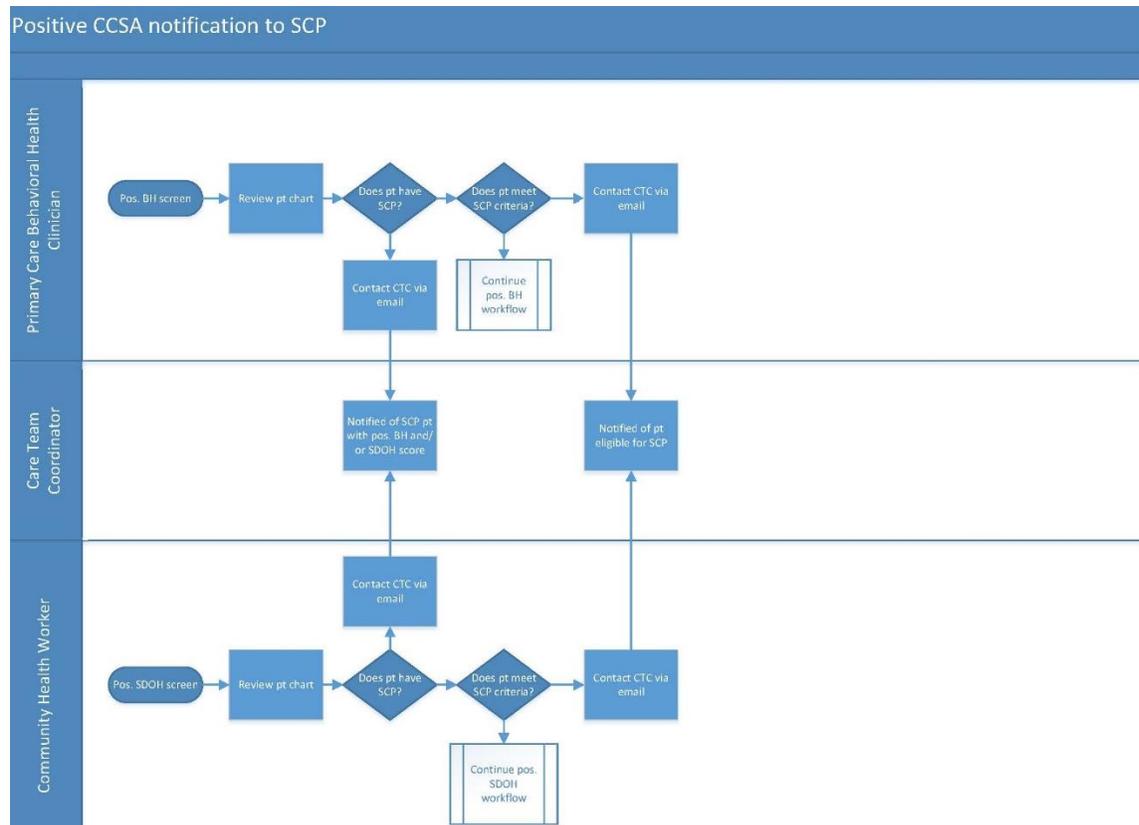
Behavioral Health and Primary Care Integration, DHMC & West Central BH			
DATE INITIATED: Sept. 2017			
<b>F – FIND a Process to Improve</b> (Background Information, Data, Value Stream Map)		<b>P – PLAN the Improvement</b> (Future State Process Map)	
West Central Behavioral Health and DHMC are the two 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.		<b>D – DO the Improvement</b> (Improvement Action Items Plan, Data Collection Plan, Forms)	
<b>O – ORGANIZE a Team</b> (List of Team & Ad-hoc Members and Roles)		 	
Tyler Vogt (DHMC), Matt Duncan (DHMC), Michelle Lin (DHMC/WCBH), Cynthia Twombly (WCBH), Joanne Wagner (DHMC), Jaime Dupuis (MaEHC), Mark Belanger (MaEHC), Chelsea Worthen (DHMC), Alex Annunziata (AmeriCorps), Molly O'Neil (UNH), Jessica Powell (IDN 1), Peter Mason (IDN 1)			
<b>C – CLARIFY Current Knowledge</b> (Current State Process Maps, Observations, Data, Specific Aim Statement)			
	<b>SPECIFIC AIM STATEMENT:</b> To improve the coordination of inter-organizational, patient-centered care for Medicaid patients with psychiatric diagnoses. This will be done through the co-creation and ongoing mutual support of an inter-organizational multi-disciplinary team (MDCT) led by a Medicaid Care Team Coordination (CTC).		
<b>U – UNDERSTAND Root Causes</b> (Fishbone Diagram, 5 Whys, Affinity Diagram)		<b>C – CHECK the Results</b> (Run Chart, Team's End Results)	
<ul style="list-style-type: none"> <li>Privacy/information sharing between organizations is a complex issue and has hindered the ability of DHMC and WCBH to coordinate care for their shared patients. In order for the two providers to work collaboratively and have a shared care plan (SCP) for high-risk patients the consent process needed to be addressed.</li> <li>Identification of patients that may not be accessing primary care regularly is also a challenge. A CCSA has been put in place to regularly identify patients that need additional supports, but it has been difficult to find patients that are eligible for SCP/MDCT.</li> </ul>		<ul style="list-style-type: none"> <li>Consent form developed</li> <li>8 MDCT meetings since May 2018</li> <li>6 active SCP patients, 2 additional consented</li> <li>2 primary care clinic sites participating</li> </ul>	
<b>S – SELECT the Improvement</b> (Benchmarking/Best Practices – External and/or Internal)		<b>A – ACT and Determine Next Steps</b> (Action Items, Lessons Learned, Sustainability Plan)	
#	ROOT CAUSE(S)	BEST PRACTICE(S)	CHANGE IDEA(S)
Sharing of information across organizations –A consent form and process was developed that addressed the sharing of information for the SCP and MDCT Additional methods to identify eligible patients –Regular reports were pulled to identify shared patients both by WCBH and DHMC. Team is looking into regular ED utilization and inpatient psychiatric discharge reports.			
<ul style="list-style-type: none"> <li>Continuing to discuss new ways to identify eligible patients for the SCP and MDCT meetings (e.g. ED utilization reports, inpatient psych discharge reports, and others)</li> <li>Involving community partners</li> </ul>			

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

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

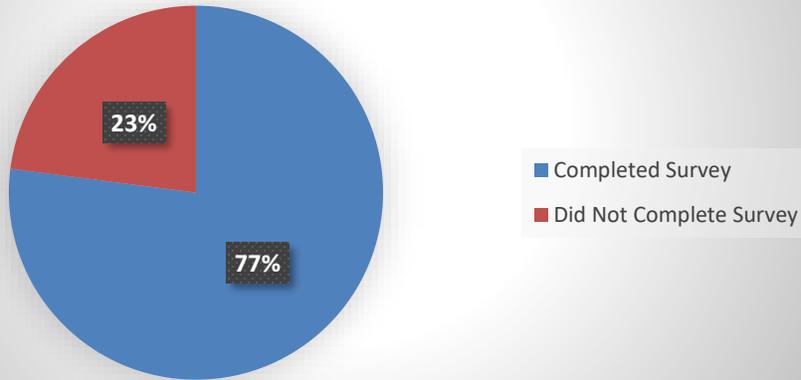
## CCSA

- For patients who receive care at DHHS and WCBH, responsibilities for completing the CCSA are shared between the two organizations. Each organization uses its own survey instrument but both instruments cover required domains.
  - The project team has seen value in coordination through the SCP in the screening identification and follow up.
- For positive CCSA's that trigger SCP notification the following workflow was constructed in Fall, 2018

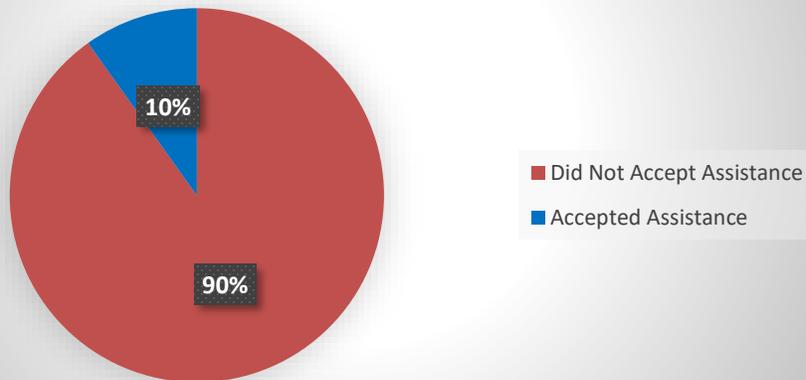


- The team has been screening for SDOH in a bundle and for BH conditions as clinically indicated since late CY2017- as of late November the full practice site of Heater Rd. S went live with the CCSA. The December stats are listed below:
  - # CCSAs assigned to appointment for Medicaid beneficiaries 28 = 6
  - # CCSAs completed 12 = 6
  - # positive screens for SDOH +/- BH symptoms = 6
- The team is working on methods for quarterly stat reporting around CCSA responses, + screens and trending SDOH areas. It is anticipated there will be more robust data to support upcoming reporting periods.
- See below for SDOH screener stats reflecting the term from its Nov'17 deployment through CCSA launch as of Dec'18:

### Eligible Patients Screened for SDOH Nov2017-Dec2018



### Would you like help? Nov2017-Oct2018

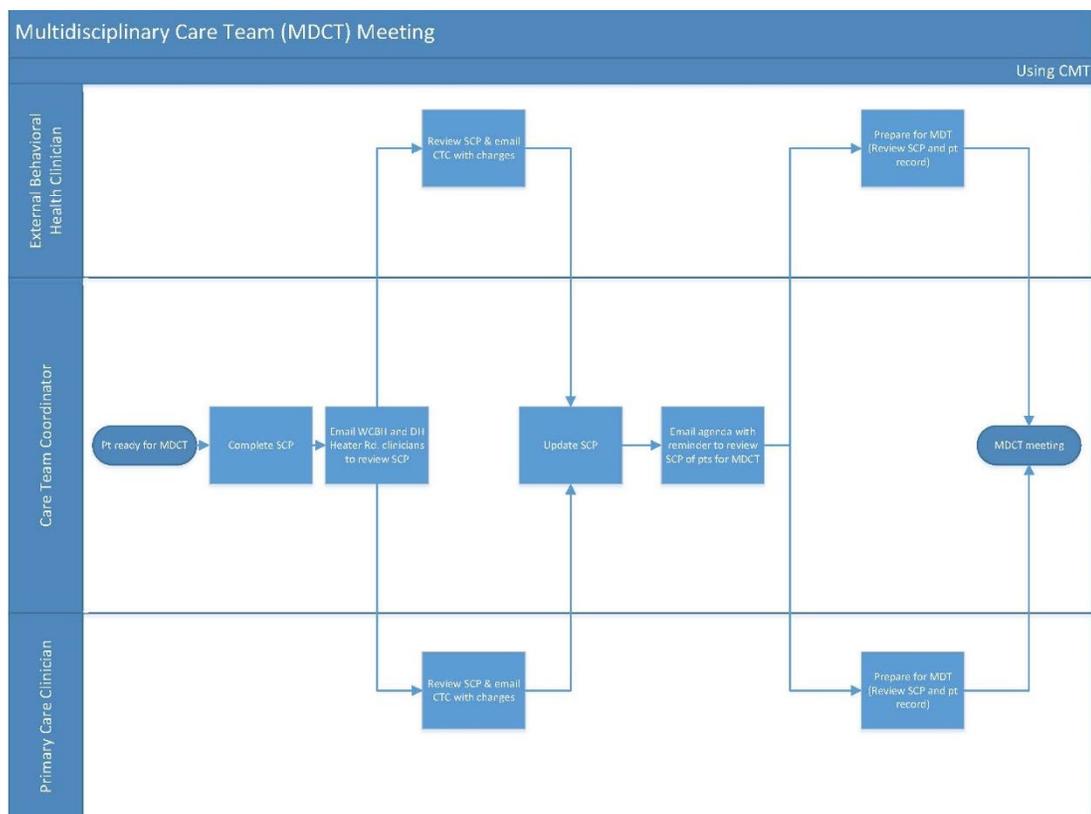


### Prevalence of Need by Domain Nov2017-Dec2018



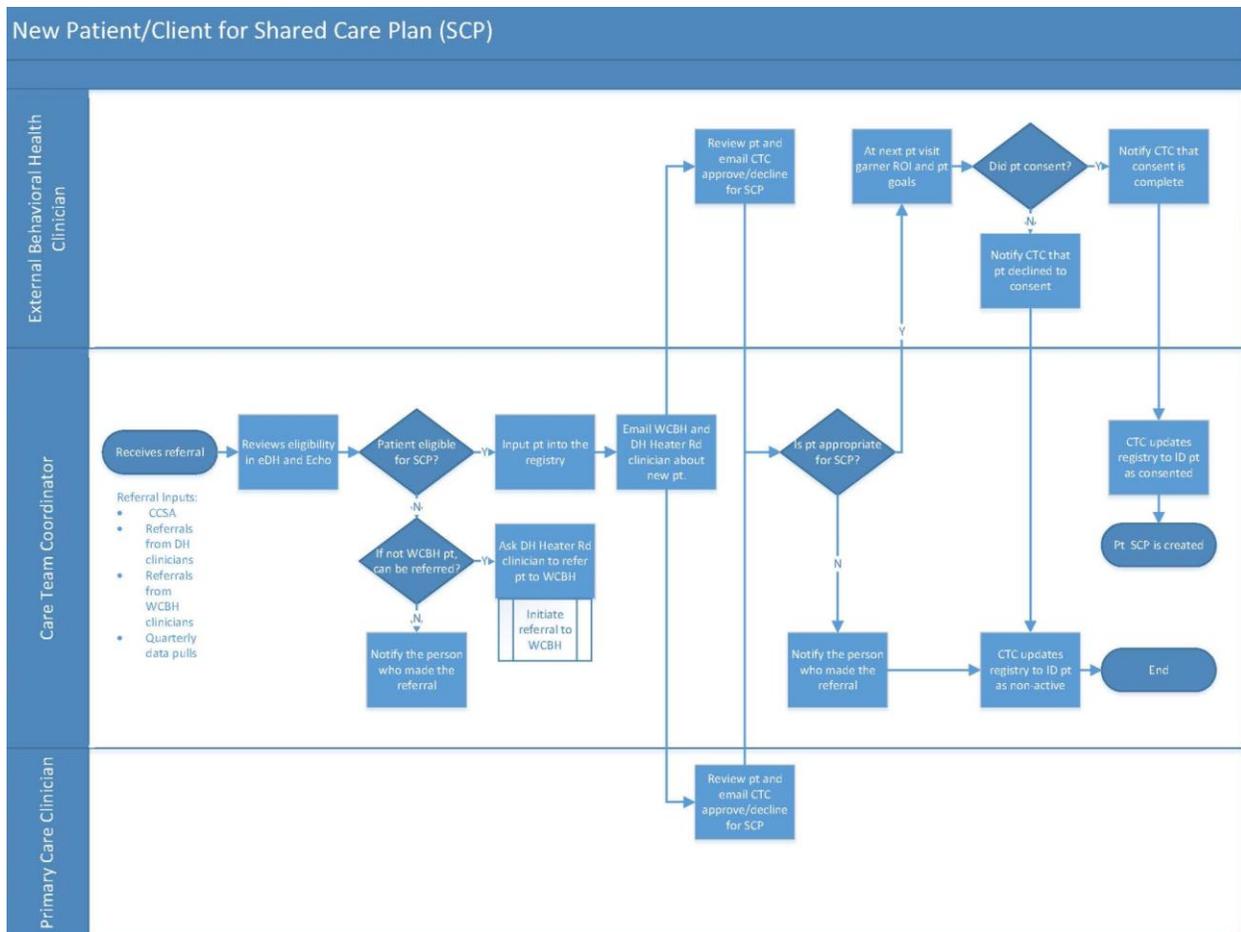
## MDCT

- The team targeted and met an early May, 2018 launch of the Multi-Disciplinary Care team (MDCT). This required a process flow for SCP creation and revision, DH-HRS and WCBH workflows around MDCT participation. The below MDCT map was updated in fall, 2018 to accommodate for team growth and streamlined processes around MDCT meetings including the electronic CMT SCP platform.
- As of reporting the team has completed 8 sessions of the MDCT and is continuously expanding program size. Currently there are 6 active shared care plans being addressed at the MDCT's. 3 additional patients have been consented. The team continues to refine their processes for patient volume discussed at each meeting, sun-setting patients whose care plans are functioning well.



## SCP

- The CTC enabled use of the shared care plan (SCP) in late March, 2018 for a pilot involving 4 patients. This process was supported by the team's creation of an interim SCP tool to be used pending the installment of re-disclosure language in the CMT software Shared Care Plan. Over the past semi-annual period the team continues to expand their patient population for MDCT and SCP.
- For positive CCSA's that trigger SCP notification the following workflow was constructed in Fall, 2018



- To allow for the MDCT and SCP to proceed WCBH needed to engage with IDN1 funded legal resource for a review of their existing consent forms and a training for all of their clinician teams on the B1 project overview, review of the consent script, and introduction to the CTC.
  - The consent process required WCBH to re consent the initial 4 patient pilot pool. Using this opportunity as a PDSA the DH-HRS/WCBH team has added SCP context language to the consent process and provided the WCBH clinicians with a clear script to guide their conversation in pursuing patient consent. Example of the provider/patient consent language below:
    - “I’d like to talk to you about your Shared Care Plan. As it is a new nationwide program, we now need to obtain new consent forms to allow all of your **past, present, and future treating providers to view your care plan as needed.** (If it applies to them: **Furthermore, we do need your written permission for sharing information pertaining to your SUD treatment plan. This information requires a separate consent to use on your electronic Shared Care Plan.**) At any time you may request in writing, an audit of who has viewed your Care Plan. We will check in with you to make sure your health/behavioral health goals are up to date and we can update or remove any goals that are accomplished or have changed at any time. This plan is in place to help facilitate better communication between your care teams at different facilities.”

## Timeline for Remaining Implementation to CCD:

- As of reporting submission the team has met Coordinated Care Designation and will continue to work towards higher level integration.

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

### Project Overview

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

### Current State: July 1, 2018-December 31, 2018

- The GIM Project team continues to meet bi-weekly and prepare for hiring, rollout of the CCSA screening, and work through adoption of the defined workflows and practices of the HRS B1 team.
- The CTC has been meeting and presenting to primary care staff to begin the process of project launch
- The embedded BHC are working with DH Psychiatry leadership and the HRS counterparts to better frame out the needs and tailoring for the clinical workflows at GIM
- Pending CCSA launch in early winter, 2019
- Pending launch of MDCT in early winter, 2019
- CMT demo scheduled for onboarding web based SCP to be shared with WCBH, DH Psych. access
- 3 shared WCBH/GIM patients have been pre-consented and will be the pilot group for the team's MDCT launch.
- There is an impending staff transition for the practice, the departure of the Primary Care Practice Manager. There has not been notification to date of the new hire but the team feels confident with the support of DH and IDN project management/ facilitation resources there will not be significant impact to the project team rollout.

- See below for high level of the ongoing team work plan:
  - Given the early project stage there is little information yet complete- additional components will be updated over the next term of implementation and a full team workplan will be shared in appendices in the upcoming reporting term.

Deliverable/Milestone	Target Start	Target Completion	Status	Notes
<b>Implementation Plan: DH/WCBH</b>				
<b>Assessment of Current State of Practice Against SAMHSA Framework for Integrated Levels of Care and Gap Analysis</b>				
Administer Site Self-Assessment to all B1 Staff every 6 months	9/1/2017	Ongoing	Completed	
Review SSA results with B1 Providers	10/1/2017	Ongoing	Complete	
<b>B1 Meetings</b>				
Practice Team Meetings	Ongoing		Complete	Bi-weekly for GIM, switch to monthly for HRS
<b>Comprehensive Core Standardized Assessment</b>				
Continue CCSA development and coordination with DH SDOH taskforce	Ongoing		Complete	
Training across B1 teams on CCSA Implementation		Ongoing	In process	
Integrate finalized CCSA into existing EMR		Ongoing	Complete	
Integrate CCSA into workflow	Ongoing	Ongoing	In process	Complete for HRS, will be done for GIM in upcoming months
Regularly monitor CCSA data		Ongoing	Complete	
<b>Workforce Staffing</b>				
Define and recruit BHC for HR			In process	
Define recruit to hire activities for the CHW role at GIM			In process	CHW will begin 2/11
<b>Target Population</b>				
Create a registry of Medicaid beneficiaries	Ongoing		Complete	
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems	Ongoing		Complete	
Create a list of the most common behavioral/mental health problems seen in this population and their frequencies	Ongoing		Complete	Tracking this regularly for the pts that meet MDCT/SCP criteria
Create referral processes for population eligible for MDCT/SCP			Complete	Looking into reports for ED utilization, inpatient psych discharge
<b>Multi-disciplinary Core Team</b>				
Assign patient/families to MDCTs	Ongoing			
Develop workflow/protocol for MDCT meetings	1/1/2018	2/28/2019	Complete	Complete for HRS, in process GIM
Monthly MDCT meetings occurring	Ongoing		Complete	Complete for HRS, in process GIM
<b>Training</b>				
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	9/1/2018	Ongoing	Complete	
Train MDCT in roles and responsibilities	Ongoing		Complete	
Train MDCT in use of SCP and secure messaging	Ongoing		Complete	

Train community partners in use of SCP and secure messaging	Ongoing	In process	Adding first community partner to HRS
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### Timeline for Remaining Implementation to CCD:

- As the project team continues to work diligently weekly to ramp up provider buy in, preparedness for CCSA launch barring any significant internal practice shifts is targeted for mid-February, 2019.
- Between mid-February and mid-March the team will work through pilot implementation of the Shared Care Plan (electronic) and MDCT flow with WCBH supporting.
- The team targets full spread of all CCD requirements by June, 2019.

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

*See appendix B1-2: VRH/CA for updated Workplan (Jul-Dec, 2018)*

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

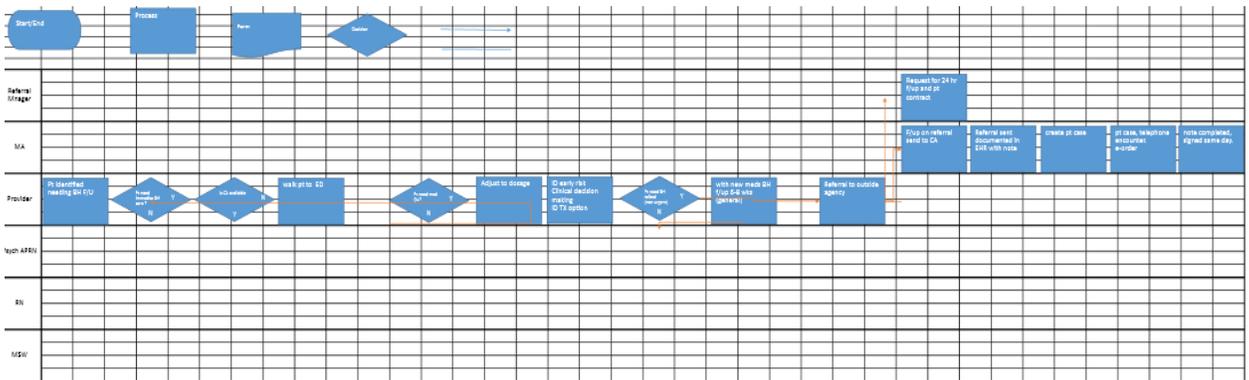
### Current State: July 1, 2018-December 31, 2018

#### Project Workflows and Team Development

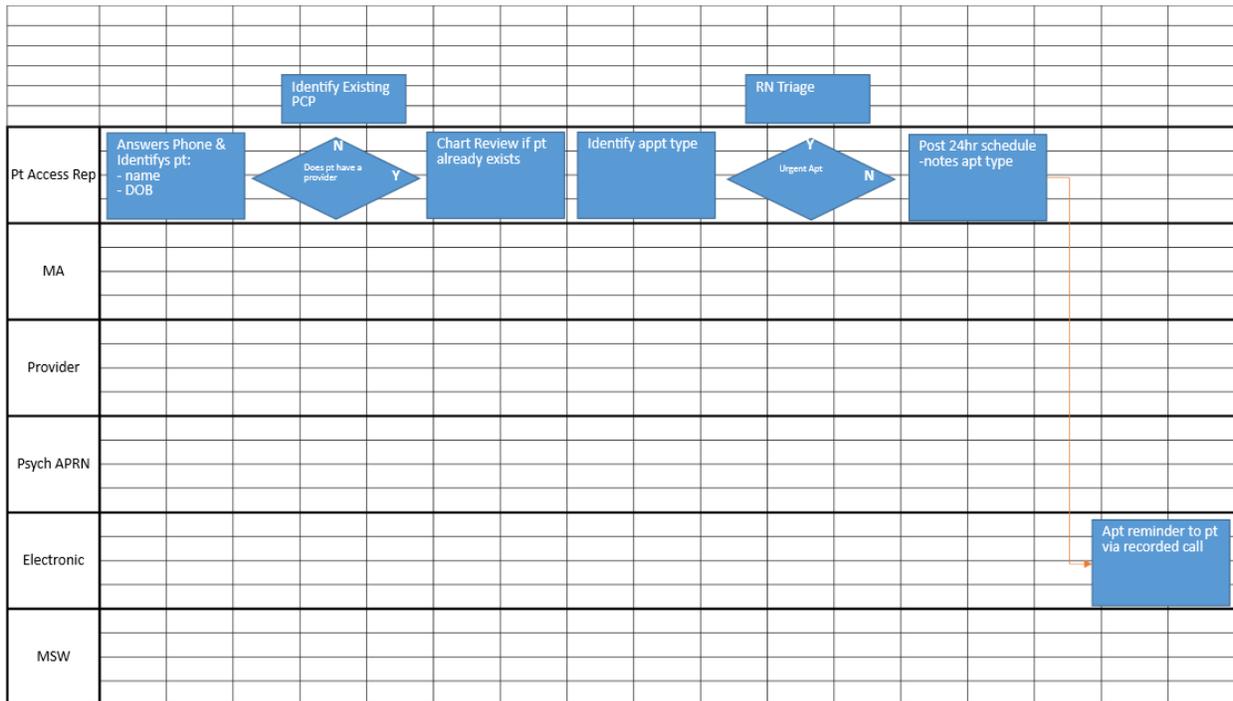
- The project team meets every week in either a full team meeting including clinical staff at both VRH and CA or with a small planning sub group that acts as a project team steering committee.
  - Meetings have been underway since late fall, 2017.
- The team has completed and works off of a charter, and work-plan milestone document that guides their implementation timelines
- As of October, 2018 the team was fully hired with
  - 1 FTE MSW (Hired in May, 2018)
  - 1 FTE RN (Funded by VRH- Supporting IDN rollout)
- The team continues to engage Sullivan county community resources and hosted an early winter Year 1 Celebration event to congratulate the community on nearly 1 year of project implementation. See below for small list of key providers:



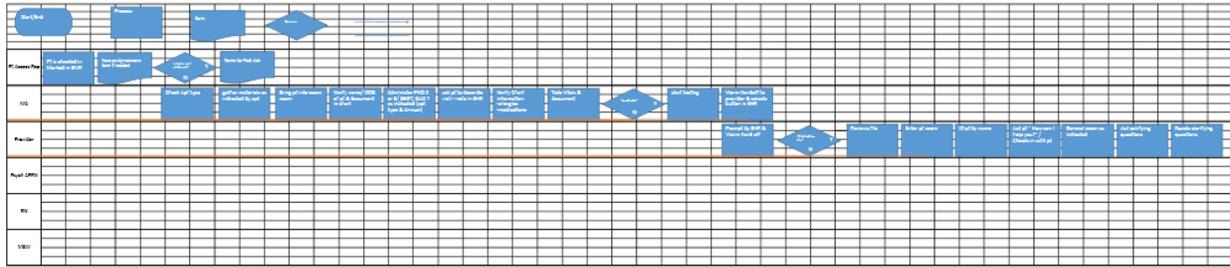
- Team Workflows: See below



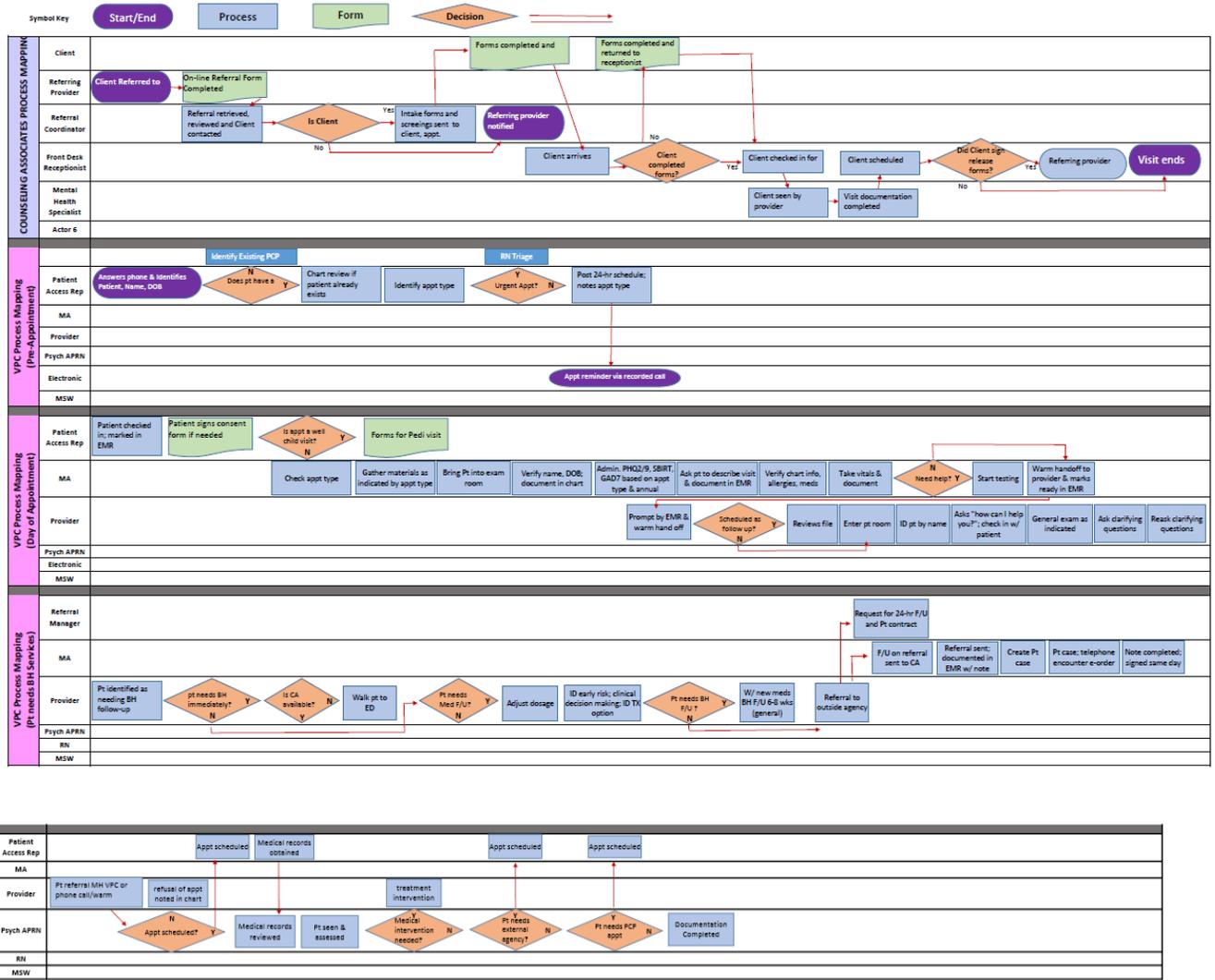
Pre- Appointment- VPC Process Map:



Appointment Day of- VPC Process Map:



Combined CA/VRH Process Mapping:



- The extensive process mapping and workflow mapping created by the team served to orient both organizations to the others processes as well as to highlight areas where process and clinical flow is needed to launch the CCSA, MDCT and utilize SCP. Additionally, refining the referral process across both sites will serve as a foundation for the expanded relationship and enable closed loop referrals. *(No change as of July-December, 2018)*
- The project manager, practice director, physician champion, practice nurse manager and MSW CTC from VPC attended both days of the IDN1 Cherokee Health sponsored training and participated in the BHC specific training in September. Numerous clinicians from Counseling Associates also attended and both groups worked together through breakout exercises on project specific development.
- The project team continues to look at opportunities for Telehealth and psych. VPC is in contract with DH for these services and looking to build from the existing work there.
- After exploring Dynamap options and licensure capacity for Counseling Associates it has been determined that there is no current way forward for the inclusion of blood pressure readings to occur with CA under their current business model/scope of service and State of NH licensure. The team continues to look for inventive and new functions to support management of their dual diagnosed and chronically unmanaged population.
- The team is coordinating with data and analytics staff at VPC and the partners at CA to address outcome reporting. The group lead team exercises in July to look at the priority areas aligning with the proposal.
  - Both organizations worked diligently with the IDN data team throughout late summer, fall, 2018 to onboard and put into use the IDN IT platforms. Additionally, to complete the required reporting for IDN submission.
- See updated team A3 below. As the IDN1 team with support from the QI coaches continues to move projects along the continuum we are introducing new QI tools and standardized processes to help sustain the work as project facilitation scales back;

**TITLE: IDN 1 B1 Valley Regional Hospital and Counseling Associates**  
**DATE INITIATED: November 2017**

**F – FIND a Process to Improve (Background Information, Data, Value Stream Map)**  
 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. catchment area.

**O – ORGANIZE a Team (List of Team & Ad-hoc Members and Roles)**  
 Juliann Barrett, DO, Krista Lafont-Leamey, MSW, Judy Carr, Gabrielle Cummings, CMA, Mariah Taylor, CMA, Krista Wilson, Michelle Premo, RN, Tracey Thibodeau, Susan Borchert (CA), Kelly Murphy

**C – CLARIFY Current Knowledge (Current State Process Maps, Observations, Data, Specific Aim Statement)**

**P – PLAN the Improvement (Future State Process Map)**  
**D – DO the Improvement (Improvement Action Items Plan, Data Collection Plan, Forms)**

Coordination of care with external behavioral health partners  
 Meeting monthly to discuss shared patient which meet criteria

Spread of screening and connection to treatment  
 Hire Community Health Navigator

Hire Masters of Social Work to fill roll of Behavioral Health Consultant  
 Increase in services offered to patients needing BH, SDOH, develop registry to monitor patient progress and assess population level data

Screen SDOH, PHQ, GAD, Cage  
 Started 10/4 screened 10 pts by 11/12  
 Spread to other apt types reassessed for additional 8 patients. Total to date 24 screened

**U – UNDERSTAND Root Causes (Fishbone Diagram, 5 Whys, Affinity Diagram)**  
 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.

**S – SELECT the Improvement (Benchmarking/Best Practices – External and/or Internal)**

#	Root Cause (S)	Change Ideas
1	Improved screening for pts needing BH/SUD services	Screen using PHQ, GAD, Cage, SDOH
2	Access to BH Services/Coordination of Care	Hire BHC and partner with local BH Services
3	Addressing SDOH needs	Hire Community Health Navigator

**C – CHECK the Results (Run Chart, Team's End Results)**

**CCSA POSITIVE SCREENINGS 10/4/18 - 12/3/18**

PHQ9 GAD7 CAGE SDOH

**A – ACT and Determine Next Steps (Action Items, Lessons Learned, Sustainability Plan)**

- Onboard Community Health Navigator
- Spread pilot across all primary organizations
- Develop pilot for Pediatric population
- Implement telehealth services for access to Psychiatry

- The team is following and updating their quarterly evaluation framework. See below for current milestones.

Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
<b>Project Q3 (Grant Q1, Y2): July 1, 2018-September 30, 2018</b>						
VRH, CA	Milestone 1 : Completion of CCSA Document and Pathways	Final Draft	Met			
	Milestone 2 : Completion of Standardized Workflows and Protocols for CCSA	Workflow Drafts	Met			
	Milestone 3 : Development of MDCT Meetings in Q4	Meeting Schedule	Met	Met	Met	Met
<b>Project Q4 (Grant Q2 Y2): October 1, 2018-December 31, 2018</b>						
VRH, CA	Milestone 1 : CCSA Launch for Eligible Patients	Use Data	Met			
	Milestone 2 : Development of SCP consent and protocol	6 Month Schedule	Met			
	Milestone 3 : Completion of standardized workflows and protocols for MDCT	Workflow Drafts	Met			
	Milestone 4 : SCP Launch for (minimum 4 patients)	SCP Draft Fields	Met			
	Milestone 5 : MDCT launch (early Nov.)	Meeting Notes	Met			
	Milestone 6 : PDSA for CCSA implementation	Documentation of Review	Met	Met	Met	Met

## CCSA

- Given ongoing constraints and challenges with VRH's shifting EHR systems and the current dual EHR environment in which the ambulatory practices are on a separate system than the hospital and registration dept. the team continues to use SCP and CCSA processes on paper.
- CCSA Screenings commenced in fall, 2018 for the pilot population.
- Current screening statistics through December 31, 2018 are as follows:

- # of Medicaid beneficiaries screened w/ CCSA: 25
  - # of those screened with positive scores: 20
  - # referred out for services: 6
    - The low referral number reflects the following experiences: 1) declining to meet with social work; 2) declining referrals, 3) lack of follow up from patient following initial assessment (no show and no response to efforts to reach out), or 4) the need was able to be addressed w/out an outside referral being made.
- The team continues to expand the eligibility pool of patients receiving the CCSA at their visits throughout VPC and its providers. With this expansion there is anticipated a significant increase in screening volume through January, February 2019.
- Additionally, as the process increases there is anticipated quarterly review of CCSA statistics
- Current draft of the VRH CCSA document included below. Current implementation is in PDSA and updates will be included in subsequent reporting:



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

Valley Primary Care  
Patient Questionnaire

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

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

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

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

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

- Oven or stove does not work
- Bug infestation
- Mold
- Lead paint or pipes
- Water leaks in the building
- Not enough heat or hot water
- No smoke detectors or they don't work
- Other \_\_\_\_\_

**3. In the past 3 months has a lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**

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

**4. How hard is it for you to pay for your basic needs of food, housing heat or medical care?**

(check one)

- Not hard at all
- Somewhat hard
- Very hard

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

- Food
- Housing
- Childcare
- Health needs
- Utility bills (electric, oil, propane, etc.)
- Debts
- Other \_\_\_\_\_

**5. In the past 3 months have you felt unable to afford your medications?**

\_\_\_\_Yes \_\_\_\_No

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

\_\_\_\_Yes \_\_\_\_No

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

- Worked for pay
- Attended school
- Household duties
- Unemployed
- Permanently unable to work
- Retired
- Other \_\_\_\_\_

Answer each question by checking Yes or No	Yes	No
8. Do you drink alcohol or use non-prescribed drugs? (if NO, skip to Q13)		
9. Have you ever felt you should cut down on your drinking or drug use?		
10. Have people annoyed you by criticizing your drinking or drug use?		
11. Have you felt bad or guilty about your drinking or drug use?		
12. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover or eye-opener?		
13. In the past 12 months, have you been threatened or scared by another person?		
14. In the past 12 months, have you been forced to perform sexual acts?		
15. Do you have legal issues that are getting in the way of your health or healthcare?		

16) During the past 2 weeks, how often have you been bothered by the following?	Several Days (1)	Over half the days (2)	Every Day (3)	Not at All (0)
... Feeling nervous, anxious or on edge				
... Not being able to control or stop worrying				
... Little interest or pleasure in doing things				
... Feeling down, depressed or hopeless				
... Thoughts that you would be better off dead or hurting yourself in some way				

In general, would you say your health is: \_\_\_Excellent \_\_\_Very Good \_\_\_Good \_\_\_Fair \_\_\_Poor

Are you currently receiving help for any needs mentioned in this questionnaire? \_\_\_Yes \_\_\_No

Do you have someone you could call if you need help or a favor? \_\_\_Yes \_\_\_No

What additional need(s) do you have that is not addressed above?

Please give this completed form to your nurse. Thank you!!

- See below for draft versions of the pediatric youth questionnaire and questionnaire for parents:



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

Valley Primary Care  
Youth Patient Questionnaire

<b>PATIENT'S</b>	First Name	Middle Name	Last Name	<b>Patient Date of Birth</b> (dd/mm/yyyy)
Do you need help reading or understanding health information? <input type="checkbox"/> Yes <input type="checkbox"/> No				

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

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

Not difficult at all \_\_\_ Somewhat difficult \_\_\_ Very Difficult \_\_\_ Extremely difficult \_\_\_

During the PAST 12 Months, did you:		Yes	No
1.	Drink any <u>alcohol</u> (more than a few sips)? (Do not count sips of alcohol taken during family or religious events)		
2.	Smoke any <u>marijuana or hashish</u> ?		
3.	Use <u>anything else</u> to <u>get high</u> ? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
1.	Have you ever ridden in a <b>CAR</b> driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2.	Do you ever use alcohol or drugs to <b>RELAX</b> , feel better about yourself, or fit in?		
3.	Do you ever use alcohol or drugs while you are by yourself, or <b>ALONE</b> ?		
4.	Do you ever <b>FORGET</b> things you did while using alcohol or drugs?		
5.	Do you <b>FAMILY</b> or <b>FRIENDS</b> ever tell you that you should cut down on your drinking or drug use?		
6.	Have you ever gotten into <b>TROUBLE</b> while you were using drugs?		

What additional need(s) do you have that is not addressed above?

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*Please give this completed form to your nurse. Thank you!!*



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

<b>PATIENT'S</b>	First Name	Middle Name	Last Name	<b>Patient Date of Birth</b> (dd/mm/yyyy)
<b>PERSON COMPLETING FORM</b>	First Name	Middle Name	Last Name	<b>Relationship to Patient</b>
<b>How confident are you when filling out forms about your child?</b>				<b>Today's Date</b>
<input type="checkbox"/> Not confident <input type="checkbox"/> A little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely confident				
Are YOU the Legal Parent or Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you need help reading or understanding health information? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**1. What is your family's housing situation today? (check one)**

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

**2. Does your family's housing situation include any of these issues? (check all that apply)**

- Oven or stove does not work
- Bug infestation
- Mold
- Lead paint or pipes
- Water leaks in the building
- Not enough heat or hot water
- No smoke detectors or they don't work
- Other \_\_\_\_\_

**3. In the past 3 months has a lack of transportation kept you or your child from medical appointments, meetings, work or from getting things needed for daily living?**

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

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

- Not hard at all
  - Somewhat hard
  - Very hard
- b) If **Somewhat Hard** or **Very Hard**, what do you have trouble paying for? (check all that apply)
- Food
  - Housing
  - Childcare
  - Health needs
  - Utility bills (electric, oil, propane, etc.)
  - Debts
  - Other \_\_\_\_\_

**5. In the past 3 months have you felt unable to afford your family's medications?**

\_\_\_\_Yes \_\_\_\_No

**6. In the past 3 months have you felt the need to sell your medications for your family's food, housing, heat, etc?**

\_\_\_\_Yes \_\_\_\_No

	Homeschooled	Yes	No	Not Applicable
7. Is your child enrolled in school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child have a job?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	(circle one)	
9. Does your child have an IEP or 504 plan in place in school?	Yes	No
10. Does your child receive counseling?	Yes	No
11. Do you limit screen time (tv, computer, video games, phone) in your family?	Yes	No
12. Is soda or sugary drinks (fruit juice, sweet tea, sports drinks) available in your home?	Yes	No
13. Do you struggle to provide any of the following for your child?		
Breakfast at home	Yes	No
Fresh fruit and vegetables	Yes	No
Exercise or other physical activity	Yes	No
14. Has your child had an emergency room visit in the last 90 days?	Yes	No
15. Does your child exercise or play sports that make him/her sweat or breathe hard for 30 minutes at least 3 times per week?	Yes	No

16. During the past 2 weeks, has your child shown any of the following? Put an "X" in the box describing what you have seen.	(0) Not True	(1) Sometimes	(2) True
S/he felt unhappy or miserable.			
S/he didn't enjoy anything at all.			
S/he felt so tired that s/he just sat around and did nothing.			
S/he was very restless.			
S/he felt s/he was no good anymore.			
S/he cried a lot.			
S/he found it hard to think properly or concentrate.			
S/he hated herself/himself.			
S/he felt s/he was a bad person.			
S/he felt lonely.			
S/he thought nobody really loved her/him.			
S/he thought s/he could never be as good as other kids.			
S/he felt s/he did everything wrong.			

17) In the past 12 months, have you or a family member been threatened or scared by another person? \_\_\_ Yes \_\_\_ No

18) In the past 12 months, have you or a family member been forced to perform sexual acts? \_\_\_ Yes \_\_\_ No

19) Do you or your family have legal issues that are getting in the way of your health or healthcare? \_\_\_ Yes \_\_\_ No

20) Do you have additional concerns about your child's wellbeing? \_\_\_ Yes \_\_\_ No

What additional need(s) do you have that is not addressed above?

\_\_\_\_\_

- Additionally, the team has formalized their clinical response pathways and continues to work in PDSA to refine and tailor as needed. See examples below:

Assessment Question #1: Do you ever need help reading or understanding your health information?

**Literacy, Communication & Education Pathway**

Source: VPC custom question to identify barriers in literacy, communications & education

Pathway:

<b>Initiation:</b> Patient identifies literacy, communication and/or education needs.	NOTES:
Identify if patient needs assistance with reading forms or from an interpreter.	
Reason for need (check all that apply): <input type="checkbox"/> Difficulty reading <input type="checkbox"/> Difficulty writing <input type="checkbox"/> Additional education needed for desired employment <input type="checkbox"/> Incomplete degree <input type="checkbox"/> Language need (e.g. English as a second language) <input type="checkbox"/> Identified Learning Disability <input type="checkbox"/> Other: _____	
Identify highest level of education completed: <input type="checkbox"/> Highest grade level: ____ <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Associates degree <input type="checkbox"/> Some college <input type="checkbox"/> College degree <input type="checkbox"/> Graduate degree	
Partner with patient to establish referrals to area community agencies.	
Confirm that patient has connected with community resources in one week.	
<b>Completion:</b> Provide follow-up with patient after one month, or referring agency if privacy release is in place.	

Name(s) of organization(s) assisting with this pathway:

Reason if pathway is incomplete:

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

Assessment Question #2, 5, 6, 7: What is your housing situation today; how hard is it for you to pay for the basic needs; in the past 3 months, have you felt the need to sell your medications for basic needs; have you felt unable to afford your medications?

**Financial Assistance Pathway**

Source: (#2, 5) CMS; <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf> (#6,7) VPC created

Pathway:

<b>Initiation:</b> Patient identifies financial assistance needs.	NOTES:
Identify types of assistance needed (check all that apply): <input type="checkbox"/> Income support/TANF <input type="checkbox"/> Rent <input type="checkbox"/> Child care <input type="checkbox"/> SSDI/SSI <input type="checkbox"/> Fuel Assistance <input type="checkbox"/> Vehicle repair ( <i>trigger Transportation Pathway</i> ) <input type="checkbox"/> Other: _____	
<input type="checkbox"/> WIC <input type="checkbox"/> Utilities <input type="checkbox"/> Debt Services <input type="checkbox"/> SNAP	
Collect patient's history of financial assistance. Partner with patient to contact appropriate resources; call and/or schedule meetings if possible. Help patient prepare for meetings with required documentation, child care, transportation, and other needs. Check town offices for emergency funding	
Confirm that patient kept appointments if scheduled; accompany patient to appointment if needed. Confirm that patient has completed applications or other paperwork; assist patient as needed.	
As appropriate, monitor applications and follow up immediately with any required information	
<b>Completion:</b> Provide follow-up with patient after one month, or referring agency if privacy release is in place.	

Name(s) of organization(s) assisting with this pathway:

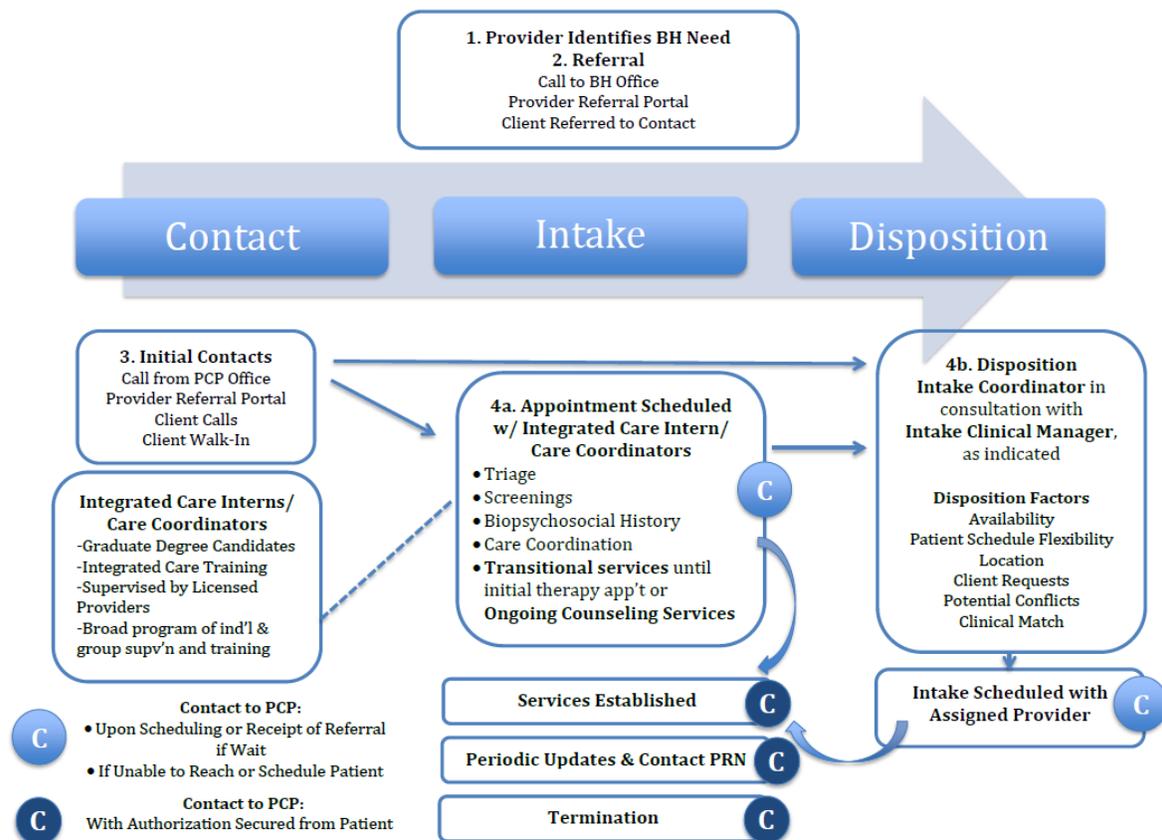
Reason if pathway is incomplete:

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

## MDCT/SCP

- VPC has aligned directly with WCBH for BH services as well. With 2017 data showing there are 410 represented shared Medicaid patients in Sullivan County between the two organizations there have been numerous MDCT/SCP candidates who have elevated between the two organizations.
- The VPC team has held 2 MDCT sessions and has included providers from WCBH and Counseling Associates to date.
- This process has strengthened referral relationships between the organizations and led to updated communication pathways.
- To date one shared care patient reviewed with several in the consent process, two MDCT session with WCBH.
- The CTC/MSW has worked to create scripts, meeting roles and ensure feedback loops are in place with the participants of the MDCT. This has greatly supported the efficacy of the meetings and streamlined the transition roles for the separate BH organizations participating.
- See below for a referral workflow that maps the process for referrals and BH management by Counseling Associates:

### Project Planning: B1 Access - Provider Referral to Behavioral Health



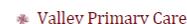
- Additionally, to support the SCP usage by VRH. The team leadership with support of VRH legal and privacy drafted the consent form below to support use of SCP for the MDCT patients:

### Special Consent for Release of Sensitive Information



Client Name:		Other Names:	
DOB:	Address:	Phone Number:	
<p><b>Purposes for Release</b></p> <p>The purpose of this form is to request and authorize Valley Primary Care to electronically transmit and disclose the sensitive information described below to past, present or future members of my Care Team through EDIE/PreManage and the Collective Medical Network for purposes of enabling members of my Care Team to provide Treatment to me.</p>			
<p><b>Consent to Release Sensitive Information</b></p> <p>I hereby request and authorize Valley Primary Care to disclose my sensitive information and records as described below through the EDIE/PreManage health information exchange functionality operated by Collective Medical Technologies, Inc. to the members of my Care Team identified below who are connected to or participate in the Collective Medical Network. This consent and request applies to information and records concerning diagnosis and treatment of me as a minor, if applicable.</p>			
<p><b>Amount and Kind of Sensitive Information to be Disclosed</b> [check ONE of the following boxes]</p> <p><input type="checkbox"/> <b>Option #1: Full Care Documentation.</b> Any of the following types of sensitive information or records which are available in Valley Primary Care electronic record (e.g., clinical notes, discharge summaries, care plans, lab results, medications, etc.) to my Care Team for purposes of providing me Treatment, including:</p> <ul style="list-style-type: none"> <li>• Substance use (alcohol or drug) diagnosis and treatment information and any information related to my treatment at, or any records from, any substance use disorder program (including medications, treatment plans, clinical assessments or tests, symptoms, diagnoses, progress notes)</li> <li>• HIV/AIDS or sexually transmitted disease (STD) diagnosis or treatment information and records</li> <li>• Mental, behavioral health and developmental disability diagnosis and treatment information and records, whether on an inpatient or outpatient, or voluntary or involuntary basis</li> <li>• Adult day program service information</li> </ul> <p><input type="checkbox"/> <b>Option #2: Limited Care Team &amp; Care Encounter Information.</b> Only my sensitive information limited to identifying: (1) the type of providers who are members of my Care Team, such as providers that specialize in substance use (alcohol or drug) treatment or referral services, mental health (inpatient or outpatient, HIV or sexually transmitted diseases, developmental disability services, adult day programs and Social Services Providers; <b>AND</b> (2) the dates, locations and types of encounters with such providers (e.g., associated diagnosis, complaint, service or location codes or information).</p>			
<p><b>To Whom My Sensitive Information May be Disclosed</b></p> <p>The sensitive information and records described above may be disclosed to all of the past, present, and future members of my Care Team (including Health Care Providers, Behavioral Health Providers, and Social Service Providers) may access my sensitive information indicated above to enable them to provide Treatment to me as part of my overall care plan.</p>			
<p><b>I understand that:</b></p> <ul style="list-style-type: none"> <li>• I am authorizing Valley Primary Care to disclose the sensitive information I have designated above, for the purposes and to the parties described in this Consent form.</li> <li>• My decision to sign this form is voluntary, and I understand that I may refuse to sign this Consent form. My refusal to sign will not affect my ability to obtain Treatment or payment or eligibility for benefits.</li> <li>• As required under federal law (42 CFR Part 2, § 2.13(d)), upon my request Valley Primary Care will provide me with a list of entities to which my sensitive information has been disclosed under this Consent.</li> <li>• I understand that I have a right to receive a copy of this consent.</li> <li>• I understand that I may revoke (i.e., take back) my Consent in writing at any time. My revocation will take effect upon receipt by Valley Primary Care except to the extent that others have already acted in reliance upon this Consent.</li> <li>• My consent will expire either upon my death, or if and when I decide to revoke it.</li> </ul>			
Client Signature:		Date:	
Legal Representative (if any):		Signature:	
Reason Client is unable to sign (if applicable):		Name:	
<p>Relationship to Client: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> Health Care Power of Attorney</p> <p><input type="checkbox"/> Other Legally Authorized Representative under applicable state law (specify: _____)</p>			

### Frequently Asked Questions



**What is the Collective Medical Network?**  
 Valley Primary Care participates in the network operated by Collective Medical Technologies, Inc. ("CMT") which connects Health Care Providers, Behavioral Health Providers, Social Service Providers, and managed care and other health insurance organizations ("Collective Medical Network"). The Collective Medical Network enables health care providers and organizations to connect and collaborate by sharing electronic health information for their shared patients through Collective Medical's EDIE and PreManage software applications so they can better coordinate their efforts to provide safe, convenient, integrated care to you.

**What are EDIE and PreManage?**  
 EDIE (sometimes called "PreManage ED") enables providers at hospital emergency departments ("EDs") to share historical summaries on your hospital visits, contact information for other providers that care for you, recommendations for how to best meet your needs when you visit the ED and other clinical information that can help these providers deliver care to you in the ED. PreManage can alert your primary care physician ("PCP"), medical clinic or other treating providers about when you have an ED visit, or when you have been discharged from the hospital after an inpatient stay and enable your health care or other providers to share other clinical information that may help them provide treatment to you or perform care coordination activities.

**Who is on my "Care Team"?**  
 Your "Care Team" includes your past, current, or future treating providers who have attested to CMT that they have a treating provider relationship with you. Your Care Team may include a variety of health care professionals or facilities, such as "Health Care Providers" which are authorized under state law to provide health care or medical services (e.g., doctors, nurses, pharmacists, hospitals, health centers, etc.), "Behavioral Health Providers" authorized under state law to provide mental health or substance use disorder or referral services (e.g., psychiatrists, psychologists, counselors or other mental health professionals or substance use counselors, social workers), or "Social Service Providers" authorized under state law to provide diagnosis, evaluation, treatment or consultation services (e.g., social workers, nurses or other individuals with such professional licensure or credentials as required under state law).

**What kind of activities does the term "Treatment" include?**  
 The term "Treatment" includes activities related to the provision or coordination of health care and related services by one or more members of your Care Team, including referral or consultation for any condition for which you may receive care, including medical, mental health, or substance use disorder. Your Care Team may work with you to develop a plan of care (or "Care Plan") that includes a summary of your diagnosis, treatment goals, and treatment activities. Treatment activities can include sharing your information as may be necessary to your Care Team to provide a referral or conduct an evaluation, to provide updates about your health care encounters or visits or new services, programs or benefits for which you are eligible, or sharing changes or updates to your Care Plan.

**Why doesn't this Special Consent Form cover my general medical information?**  
 HIPAA and applicable state privacy laws permit CMT to enable health care organizations which have a relationship with you and which participate in the Collective Medical Network to use EDIE and PreManage to share your general medical information for treatment, payment, or health care operations purposes (as those terms are defined by HIPAA) without your specific authorization or consent. CMT and the health care organizations that have a relationship with you cannot share certain categories of your "sensitive information" that are protected under state or federal law, unless you sign a specific consent form which meets applicable legal requirements. The purpose of this Special Consent Form is to enable you to authorize members of your Care Team to have access to this sensitive information to better enable members of your Care Team to provide Treatment to you.

**Am I required to participate in EDIE/PreManage or can I opt-out?**  
 Your participation is voluntary, and you may refuse to allow your information to be shared through EDIE/PreManage. You may choose not to sign this Special Consent Form, in which case your Care Team will not be able to share your sensitive information through EDIE/PreManage. You may also choose to "opt out" of allowing CMT to share your general medical information between health care organizations you work with. If you are interested in learning more about opting-out, ask Valley Primary Care for more information about opting-out of the Collective Medical Network and EDIE/PreManage.

**Will signing this Special Consent Form affect other consents or authorizations I have signed?**  
 You may have signed other consent or authorization forms, and your signing this Special Consent Form does not limit or revoke those other consents or authorizations. For example, the general consent you signed with your treating provider may authorize your provider to share information with your managed care organization or other health insurance payer for payment related purposes (e.g., to check eligibility for certain services or procedures, to obtain authorization for services, to obtain payment for services provided).

## Timeline for Remaining Implementation

- The team has not met CCD as they are not currently fully to scale across the Pediatrics population at VPC/VRH's Primary Care sites.
- Current work plans target that their full implementation will be executed as of June, 2019

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

*See appendix B1-2: CMC/MFS for updated Workplan (Jul-Dec, 2018)*

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

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

## Current State: July 1, 2018-December 31, 2018

### Project Workflows and Team Development

- The CMC/MFS team began meeting bi-weekly on Wednesday mornings in late summer, 2018. The mission of this core steering committee was to refine the proposed project and get the components underway to support project development. This group includes the CEO of MFS, Medical Director of MFS, Population Health leadership from CMC, Primary Care representation from CMC and the support of the IDN Program Director and CHI coaches.
  - The CMC/MFS has engaged a B1 QI Coach contracted through Citizens Health Initiative (CHI). The coach has a standing relationship with MFS on their ongoing QI work with CHI. Additionally, given her extensive experience with the Community Mental Health Center (CMHC) network infrastructure in NH, she has a unique view into the development of the CMC/MFS reverse integration project development.
- The CMC non-clinical lead is working directly with their IT/Data department to pull an initial patient registry list for those high acuity patients with a BH indication that are shared between CMC primary care and MFS adult services.
  - The initial data pull will identify shared patients across all of the CMC primary care providers and the team will target a phased launch with PCP's as the project gets underway.
- To guide the project work forward the steering group is working off of the following charter and aligned work-plan.

#### PROJECT CHARTER

1. General Project Information				
Project Name:	Behavioral Health and Primary Care Integration (Region 1, B1 BHI)			
Executive Sponsor:	Region 1 Executive Committee			
2. Project Team				
	Name	Organization or Department Affiliation	Telephone	E-mail
Project Leads:	[REDACTED]	[REDACTED]	[REDACTED]	<a href="mailto:lpitts@cheshire-med.com">lpitts@cheshire-med.com</a>
Data Lead:	[REDACTED]			
Pratice Facilitator	[REDACTED]	[REDACTED]		
2 <sup>nd</sup> Prac. Fac	[REDACTED]	[REDACTED]		
MFS BH Lead	[REDACTED]	[REDACTED]	[REDACTED]	<a href="mailto:pwyzik@mfs.org">pwyzik@mfs.org</a>
Team Member	[REDACTED]	[REDACTED]	[REDACTED]	<a href="mailto:mmarsh@mfs.org">mmarsh@mfs.org</a>
Team Member	[REDACTED]	[REDACTED]	[REDACTED]	<a href="mailto:atremblay@cheshire-med.com">atremblay@cheshire-med.com</a>
Team Member	[REDACTED]	[REDACTED]	[REDACTED]	<a href="mailto:slafrance@cheshire-med.com">slafrance@cheshire-med.com</a>
Team Member	[REDACTED]	[REDACTED]	[REDACTED]	<a href="mailto:efernandes@cheshire-med.com">efernandes@cheshire-med.com</a>
Team Member	[REDACTED]	[REDACTED]		

IDN Data Lead	██████████	███		
IDN PM Lead	██████████	███		
IDN MD Lead	██████████	███		
Patient/Family Representative				
<b>3. Stakeholders (e.g., those with a significant interest in or who will be significantly affected by this project)</b>				
Individuals receiving services at MFS needing primary care, families of individuals served; public guardians				
Variety of social service organizations in the region				
Ancillary departments at MFS and CMC				
Monadnock Peer Support Agency, CMC – Prescribe for Health				
<b>4. Project Scope Statement</b>				
<b>Project Purpose</b> Describe the need this project addresses				
The purpose of this project is to: 1) reduce the burden of physical and mental illness for those clients ages 12 and older with behavior health conditions through the creation of an multidisciplinary team of professionals and peer supports using best-practice coordinated care interventions and 2) develop an effective and efficient model for co-locating a Health Home in a community mental health center to deliver integrated primary and behavioral health care services that will achieve the Quadruple Aim.				
<b>Objectives</b> Describe the measurable outcomes of the project (e.g., reduce cost by xx, increase screening rates by yy)				
<p><b>Objective 1:</b> 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.</p> <p><b>Objective 2:</b> 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.</p> <p><b>Objective 3:</b> 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.</p> <p><b>Objective 4:</b> Continuously improve client and staff experience (satisfaction and quality).</p> <p><b>Objective 5:</b> Utilize the Region 1 shared IT platform to ensure coordinated care and communication across partners and care sites.</p> <p><b>Objective 6:</b> 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.</p> <p>Improve health outcomes:</p> <ul style="list-style-type: none"> <li>• Reducing ED visits</li> <li>• Reduce hypertension rates</li> <li>• Reduce diabetes rates</li> <li>• Screening rates: colon cancer, mammography, (could we get baseline data at time of interview for this project), immunizations (flu, pneumonia, tetanus, etc.)</li> </ul>				

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

Creating the patient registry

Create access to EPIC for MFS staff

Shared care plan- PreManage

Create registry to identify BH, medical and social needs:

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

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

Evaluation plan developed

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

**Scope** *List what the project will and will not address (e.g., this project addresses all Medicaid patients, Medicare patients are not included)*

- 1) In Scope-Primare care services and care coordination provided to Medicaid beneficiaries age 12 and above who receive behavioral health services from MFS
- 2) Out of Scope – MFS clients over the age of 65 who do not have Medicaid insurance
- 3) Out of Scope – individuals whose only connection to MFS is through the Emergency Services department

**Project Milestones** *Propose start and end dates for Project Phases (e.g., Planning, Implementation) and other major milestones*

See attached Project Milestones Guidance

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

▪

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

Risk	Risk Rating (Hi, Med, Lo)
Primary Care Provider not available	High
Supply costs	Low
Clients do not want primary care services	Low
Region 1 IDN funding is not available for future years	Medium
Sustainability impacted due to current funding processes	Medium

See details of the work-plan below:

Deliverable/Milestone	Task Assignments		Q1	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
<b>Implementation Year 1</b>	Lead	Support	Present - 9/30/18	10/1/18-12/31/18	1/1/19-3/30/19	4/1/19-6/30/19				
Charter Completion- Final review and approval by all project team members	Dee W.	Jessica P.						August, 2018	September, 2018	Complete
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month										
<b>Team Meetings</b>										
Set up recurring bi-weekly meetings at alternating site locations to support attendance across organizations	Dee W.	Jessica P.								Complete
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	Dee W.	Jessica P.						August, 2018	September, 2018	Complete
Support and document MDCT meetings monthly and case assessment process	Project Team to Identify							*Pending Formal Clinical Launch		
<b>Recruit to Hire - M1, 2</b>										
Document weekly progress toward position hiring and share with broader project team membership	Project Team to Identify							August, 2018	September, 2018	Complete
Share job descriptions and links to postings with all project team members	Project Team to Identify							August, 2018	September, 2018	Complete
Assign team member lead support for communication of progress and interview panel updates	Project Team to Identify								September, 2018	Complete
<b>Onboarding</b>										
Formalize and document the onboarding and training process for NP	Project Team to Identify							September, 2018	February, 2018	In Process
*Share with all project team members and address willingness to share with other programs										
Create a training plan by needed position to share and replicate for subsequent hires	All Pteam	Dee W. / Jessica P.						*Pending Initial Hire and Project Rollout		
*Address privacy and consent training for role within IDN SCP										
Address with project team onboarding activities to be supported by the IDN staff and partner network	All Pteam	Jessica P.						September, 2018		Complete

- Throughout late summer, fall of 2018 the team has been working on the following:
  - Recruit to hire activities for the APRN
    - Offer made and accepted in December, 2018
  - Facility construction and design at MFS
    - This has included finalizing supply lists, lining up construction permits for plumbing, electrical etc. to support the construction of the clinical space
    - Additionally, extensive work has gone into the design and layout of the clinic flow to support the PC APRN to have a flexible and usable work area.
    - The new hire before onboarding has been involved and visited the space to weigh in on design and things like exam table placement, office space etc.
  - Licensing and CLIA
    - The team has extensively reviewed all of the licensing, credentialing and requirements for bringing PC space into the CMHC office.
    - This has led to some delays as the group explores the regulations around blood draws, lab stations, vaccines etc.
  - EPIC Access
    - The team has worked with DH IT to develop a training plan for both the Admin staff at MFS as well as the projects supporting RN to be trained in EPIC for purposes of registration and clinical documentation.
    - The APRN during onboarding will complete the full training and spend 2 weeks shadowing in the hospital based PC at CMC
  - Billing
    - The team continues to review and refine the processes in place for enabling project billing and coding
    - There has been considerable legwork done to enable the CMHC office location as a satellite site in EPIC, refine the details of how to create a PC panel outside of one of the primary practices and many other intricacies.
  - Patient Flow Mapping
    - The CHI facilitator has worked closely with the MFS clinical leadership to map out the needs for patient flow and details for onboarding the PC.
  - Staff Training and Awareness

- The team is continuously expanding the group that is supporting this pilot work and beginning the process of presenting at team/dept. meetings to present on the pilot.
- The APRN is scheduled to start in early February, 2019 once the credentialing process has formally completed.
- Beginning in early January, 2019 the team will switch the function of these planning meetings to be more implementation focused.
- This will include training on the SCP, onboarding of the CMT platform
- Vetting of the paper CCSA to be in use until late spring, 2019 for the pilot MFS project
- Workflow development to support the MDCT meeting flow and identify primary participants

#### All Cheshire Primary Care B1 Implementation Progress:

- Outside of the meetings with the CMC/MFS pilot team the IDN Admin team has been meeting and refining a rollout plan for the spread of the CCD model (Use of CCSA, SCP, MDCT) for the full CMC primary care panel
- Much of this work is already in place under the efforts of the Prescribe for Health Initiative
- An amended SOW addendum is being drafted to supplement the subcontracted work for the CMC/MFS pilot and will look to add FTE support for a part time project manager and CHW/CTC role to support the primary care teams in responding to positive screening responses.
- Given significant leadership shifts within CMC Primary Care there have been some delays in rollout but the admin team is working diligently with CMC leadership to move forward as quickly as possible.
- The team continues to meet all quarterly evaluation criteria. See below;

Project Name, Lead Organization	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense Reports)	Accountability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
<b>Project Q2 July 1-September 30, 2018</b>						
<b>CMC, MFS</b>	Milestone 1 : Complete Patient Flows for MFS and CMC	Share Completed Mapping	Met	Met	Met	Met
	Milestone 2 : Complete Clinic Flows for All Applicable Appointment Types at new MFS site	Share Completed Mapping	Met			
	Milestone 3 : Complete Team Charter	Share Completed Charter	Met			
	Milestone 4 : Conduct Outreach to Project Involved Community Stakeholders	Share Partner Communication	Ongoing			
	Milestone 5 : Develop Standardized Workflows and Protocols for MDCT	Share Completed Mapping	Ongoing			
<b>Project Q3 October 1- December 31, 2018</b>						
<b>CMC, MFS</b>	Milestone 1 : Ongoing Bi-weekly Project Team Meetings	Calendar of Meetings	Met	Met	N/A	Met
	Milestone 2 : Documentation of Hiring Efforts	Hire Documents	Met			
	Milestone 3 : Construction and Space Design at MFS	Team Updates	Met			
	Milestone 4 : Completion of Clinic Stocking	Team Updates	Met			

### Timeline for Remaining Implementation

- CMC/MFS Pilot: With the APRN hire moving forward as scheduled in February, 2019 the team anticipates full implementation not later than end of March, 2019.
- All CMC Primary Care: The team targets full spread of all CCD requirements by June, 2019.

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

See appendix B1-2: NHC for updated Workplan (Jul-Dec, 2018)

## Project Overview

- The Newport Health Center Pediatrics team launched officially in early summer, 2018 with a small core team supported by the site MSW, Administrative support and Pediatrician.
- The initial focus of the pilot is for the adolescent pediatric population and expand to include the >12 and adult population served. Newport Health Center has a high Medicaid volume and is well-poised for the B1 project with the internal resource of a Psychiatrist and 1 FTE MSW. Additionally, the site shares space with Counseling Associates who currently offer BH services to patients 2 days a week. For the pediatric population NHC partners with the Newport School District in Newport High School through its work at the Tiger Treatment Center, which is currently staffed several mornings a week with a NHC clinician. The B1 project physician champion, is a pediatrician and the MSW coordinator are both committed to the vision of expanded services at the Tiger Treatment Center and partnering more directly with other BH services offered within the community for their high needs pediatric population. This unique model will look to embed CCSA screening within NHC as well as expanded services at the Tiger Treatment Center to identify patients who are eligible for the MDCT and augment existing crisis response with the population at NHC.
- The IDN team finally came to agreement with New London Hospital Association and signed a contract in December, 2018. The contract sets forth the details of the pilot project with NHC as well as specifies the need for expansion to NLH Adult PC and Pediatrics in the first 6 months of 2019.

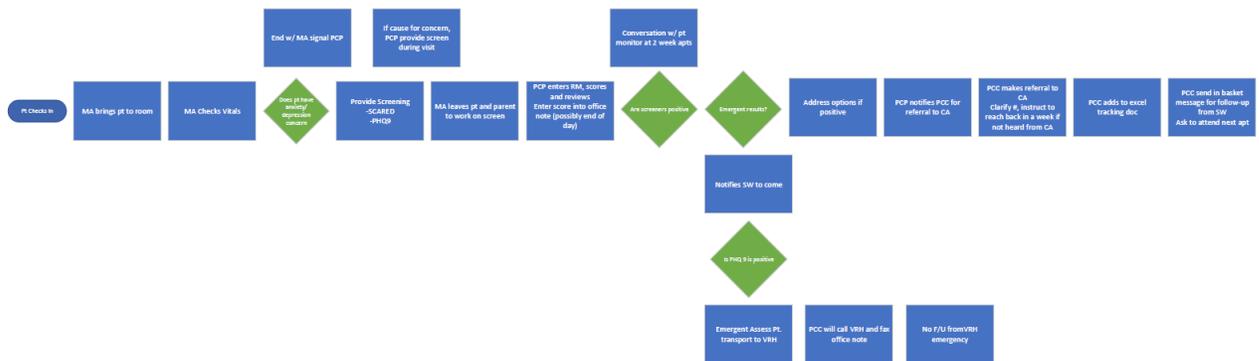
## Current State: July 1, 2018-December 31, 2018

### Project Workflows and Team Development

- The team commenced bi-weekly meetings in early summer, 2018 with a small steering group every other Friday from 12-1p
- With support of the IDN Program Director and CHI facilitator the MSW and designated CTC met extensively outside of these sessions to complete pre work and develop content to bring to the full team meetings.
- The team identified need and hired for a CHW in fall of 2018. The new hire will begin with the team in early January, 2019.
- The onboarding of this new role will allow for significant project growth and will enable the MSW to work to the higher end of their licensure on BH needs.
- The team has crafted materials to support building project awareness internal to the organization but also to the patient population as well as external community support agencies.
- To further map and track practice flow the CHI coach shadowed core practice staff for 4+hrs at each practice site creating time trials for patient rooming, visits, MA role and spaghetti diagrams modeling clinic flow will greatly support the development of sustainable clinic implementation plans.
- The team continues to meet all quarterly evaluation criteria. See below:

Project Name, Lead	Project Milestones:	Deliverable:	Met or Unmet	Use of Funds: Met or Unmet (See Supportive Budgets, Expense	Account ability of Time: Met or Unmet	Participation in IDN Activities: Baseline participation Met or Unmet
<b>Q1&amp;2: July 1- December 31<sup>st</sup>, 2018</b>						
<b>Newport Health Center</b>	Milestone 1 : Demonstrate Commitment from Primary Care Pilot Team	Self-Report	Met	Met	Met	Met
	Milestone 2 : Develop Recurring Project Team Meeting	Share Project Team Membership List	Met			
	Milestone 3 : Recruit to Hire Activities for All Open Positions	Share Job Posting, Follow up	Met			
	Milestone 4: Complete Formal Project Agreement between NHC,BH Support Agencies , and Newport School District	Share Final Document	Met			

Current State:



Future State:



- The team plans to pilot test the CCSA for well-child adolescent visits in early January, 2019 and reaching scale across all appointment types by mid-February, 2019
- Beginning in mid-February the team will work through pilot implementation of the Shared Care Plan (electronic) and MDCT flow with WCBH, CA supporting.
- The team targets full spread of all CCD requirements by June, 2019.

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

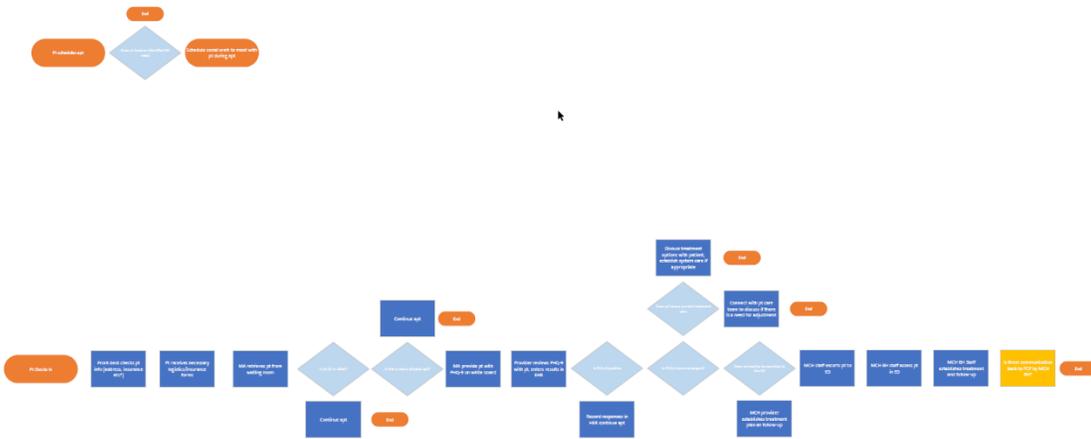
### Project Overview

- The MCH project team began meeting in early summer, 2018. The team since early fall, 2018 has been meeting bi-weekly on Monday afternoons to work through and prep for project implementation.
- The pilot team consists of representation from BH, an MSW, the Primary Care Director, Primary Care practice manager, and representation from Data/ IT as needed.
- The team will pilot with a dual launch across adults and adolescents followed by pediatrics onboarding in the same quarter. The target will be start with the primary care site in Jaffrey, adults and pediatrics based at MCH and then spread to the other satellite practices.

### Current State: July 1, 2018-December 31, 2018

### Project Workflows and Team Development

- The group began with review of their current systems as the practice site is highly unique both in their progress to date towards integration but also in the remote location of their practices. The hospital system is a one stop shop for the patients in their region and has a robust BH dept. and social work referral network embedded within their Primary Care.
- With support of the IDN Program Director and CHI facilitator the team worked through current state mapping and review of systems over the course of the summer and fall.
- The team identified need and posted for hire of 2 CHW's in winter, 2019.
- The team has crafted materials to support building project awareness internal to the organization but also to the patient population as well as external community support agencies.
- To further map and track practice flow the CHI coach and IDN Program Director shadowed core practice staff for 2+hrs at each practice site creating time trials for patient rooming, visits, MA role and spaghetti diagrams modeling clinic flow will greatly support the development of sustainable clinic implementation plans.
- Given early project stage there is no formal workplan for the MCH team to date. A full appendix work plan will be shared in the upcoming reporting term.
- Examples of the current state maps below:  
MCH Hospital Based Pediatric Primary Care:



Jaffrey Primary Care:



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

Project Name, Lead	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
<b>Q1: July 1-September 30, 2018</b>						
<b>Monadnock Community Hospital</b>	<i>Milestone 1</i> : Demonstrate Commitment from Primary Care Pilot Team	Self-Report	Met	Met	Met	Met
	<i>Milestone 2</i> : Develop Recurring Project Team Meeting	Share Project Team Membership List	Met			
	<i>Milestone 3</i> : Recruit to Hire Activities for All Open Positions	Share Job Posting, Follow up	Ongoing			
	<i>Milestone 4</i> : Complete Project Guidance Documents and Work Plan	Share Final Document	Met			
<b>Q2: October- December 31, 2018</b>						
<b>Monadnock Community Hospital</b>	<i>Milestone 1</i> : Complete Patient Flows for MCH External Referral and Screening	Share Completed Mapping	Met	Met	Met	Met
	<i>Milestone 2</i> : Complete Clinic Flows for All Applicable Appointment Types at MCH	Share Completed Mapping	Met			
	<i>Milestone 3</i> : Complete Team Charter	Share Completed Charter	Met			
	<i>Milestone 4</i> : Conduct Outreach to Project Involved Community Stakeholders	Share Partner Communication	Ongoing			
	<i>Milestone 5</i> : Develop Standardized Workflows and Protocols for MDCT	Share Completed Mapping	Ongoing			

## CCSA

- As the group is targeting a full implementation for the CCSA the project team underwent a comprehensive review of current screenings in use. Review of the practice around standardized screenings (PHQ9, GAD7)
- The project team completed a review of current screenings in place across other IDN project sites and developed the following;

<b>Name:</b>		<input type="checkbox"/> M	<b>Date of Birth:</b>	<b>Age:</b>
<b>Patient Name:</b>		<input type="checkbox"/> F		
<b>Relation to Patient:</b>				
<b>Address:</b>		STREET/APT #		
CITY		STATE		ZIP CODE
<b>Phone:</b>	HOME	CELL	<b>Best Time to Call:</b>	
<b>Marital status:</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married	<input type="checkbox"/> Separated
			<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<b>Who else in Household?</b>				
<b>Primary Language Spoken:</b> <input type="checkbox"/> English <input type="checkbox"/> Other:				
How would you rate <b>your overall health</b> ? <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Very Poor				
Do you ever <b>need help reading or understanding</b> health information? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What is your <b>housing situation</b> today? <input type="checkbox"/> I do not have housing <input type="checkbox"/> I have housing today				
Do you have <b>someone you could call</b> if you need help or a favor? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What was your <b>main activity</b> during the last 6 months? <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Student <input type="checkbox"/> Other				
Do you have <b>legal issues</b> that are getting in the way of your or your child's health or healthcare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
In the last 12 months, did you ever <b>eat less than you should</b> because there wasn't enough money or access for food?				<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 12 months, has your utility company <b>shut off</b> your service for <b>not paying your bills</b> ?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you worried that in the next 2 months you <b>may not have stable housing</b> ?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Do <b>problems getting childcare</b> make it difficult for you <b>to work or study</b> ?				<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 12 months, have you or your child <b>needed to see a doctor</b> , but <b>could not because of cost</b> ?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or your child have issues with <b>transportation</b> ?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently <b>feeling lonely or isolated</b> ?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to receive help for any needs mentioned in this questionnaire?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have <b>any concerns</b> about the following? <i>(Check all that apply)</i>		<input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Family Issues <input type="checkbox"/> Safety of your children		
		<input type="checkbox"/> Work Conflicts or Issues <input type="checkbox"/> Drug/Substance Use <input type="checkbox"/> Health/Physical Issues <input type="checkbox"/> Other: _____		

- The team will implement with:
  - PHQ9
  - GAD7
  - AUDIT
  - DAST10
    - For Pediatrics
    - PHQA
    - CRAFFT
- Social Determinants of Health: See below

What is your housing situation today?	<input type="checkbox"/>	I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
	<input type="checkbox"/>	I have housing today, but I am worried about losing housing in the future.
	<input type="checkbox"/>	I have housing
Think about the place you live. Do you have problems with any of the following? (check all that apply)	<input type="checkbox"/>	Bug infestation
	<input type="checkbox"/>	Mold
	<input type="checkbox"/>	Lead paint or pipes
	<input type="checkbox"/>	Inadequate heat
	<input type="checkbox"/>	Oven or stove not working
	<input type="checkbox"/>	No or not working smoke detectors
	<input type="checkbox"/>	Water leaks
	<input type="checkbox"/>	None of the above
How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?	<input type="checkbox"/>	Not hard at all
	<input type="checkbox"/>	Somewhat hard
	<input type="checkbox"/>	Very hard
Do you ever need help reading hospital materials?	<input type="checkbox"/>	Yes
	<input type="checkbox"/>	No
Are you married or living together with someone in a partnership?	<input type="checkbox"/>	Married or domestic partner
	<input type="checkbox"/>	Living with a partner in a committed relationship
	<input type="checkbox"/>	In a serious or committed relationship, but not living together
	<input type="checkbox"/>	Single
	<input type="checkbox"/>	Separated
	<input type="checkbox"/>	Divorced
<input type="checkbox"/>	Widowed	
<i>In a typical week, how often do you:</i>		
Talk with family, friends or neighbors by phone or video chat (e.g. Skype, FaceTime)?	<input type="checkbox"/>	Never
	<input type="checkbox"/>	Once a week
	<input type="checkbox"/>	2 days a week
	<input type="checkbox"/>	3-5 days a week
	<input type="checkbox"/>	Nearly every day
Get together with family, friend or neighbors?	<input type="checkbox"/>	Never
	<input type="checkbox"/>	Once a week
	<input type="checkbox"/>	2 days a week
	<input type="checkbox"/>	3-5 days a week
	<input type="checkbox"/>	Nearly every day
Use email, text messaging, or internet (e.g. Facebook) to communicate with family, friends or neighbors?	<input type="checkbox"/>	Never
	<input type="checkbox"/>	Once a week
	<input type="checkbox"/>	2 days a week
	<input type="checkbox"/>	3-5 days a week
	<input type="checkbox"/>	Nearly every day
<i>How often do you:</i>		
Attend church or religious services?	<input type="checkbox"/>	Never
	<input type="checkbox"/>	Once a year
	<input type="checkbox"/>	2-3 times a year
	<input type="checkbox"/>	4 or more times a year
	<input type="checkbox"/>	At least once a month
	<input type="checkbox"/>	At least once a week
Attend meetings of the clubs or organizations that you belong to?	<input type="checkbox"/>	Never
	<input type="checkbox"/>	Once a year
	<input type="checkbox"/>	2-3 times a year
	<input type="checkbox"/>	4 or more times a year
	<input type="checkbox"/>	At least once a month
	<input type="checkbox"/>	At least once a week
In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (Check all that)	<input type="checkbox"/>	Yes, it has kept me from medical appointments or getting medications
	<input type="checkbox"/>	Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
	<input type="checkbox"/>	No
What was your main activity during most of the last 12 months?	<input type="checkbox"/>	Worked for pay
	<input type="checkbox"/>	Attended school
	<input type="checkbox"/>	Household duties
	<input type="checkbox"/>	Unemployed
	<input type="checkbox"/>	Permanently unable to work
Do you have any legal issues that are getting in the way of your health or healthcare?	<input type="checkbox"/>	Yes
	<input type="checkbox"/>	No

- The team will pilot on paper and work to include in their EHR long term.

## MDCT/SCP

- The team is working closely with their internal Behavioral health dept. for MSW, PhD, PsyD, Psych. RN and Psychiatrist involvement with the project and the MDCT
  - MCH is still working on building community partnerships that would lead to external BH support.
- The pilot team has begun to map out the necessary refined referral flows and communication that will support the hospital based BH dept. to successfully support the hospital based and remote practice onboarding of the B1 project.
- Given current shortages of MSW the team is working to creatively use available resources as effectively as possible
  - The IDN is working with MCH to offer workforce recruitment funds to support the MSW positions as well as the positions being hired with IDN project funds.
- The team has begun development of the MDCT flow mock up and will review current processes in place across other sites.
- The team has been engaged with the IDN data supports to familiarize with the IT platforms and prep for SCP implementation.

## Timeline for Remaining Implementation

- The team plans to pilot test the CCSA in February 2019
- The team targets full spread of all CCD requirements by June, 2019

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

*See appendix B1-2: APD for updated Workplan (Jul-Dec, 2018)*

## Project Overview

- Given large system conversions for Alice Peck Day throughout 2018 the team began onboarding slowly throughout summer, early fall 2018.
- The team proposed to follow the AIMS center collaborative care model and moving to adoption of the full DH CCSA in EPIC in May, 2019

## Current State: July 1, 2018-December 31, 2018

## Project Workflows and Team Development

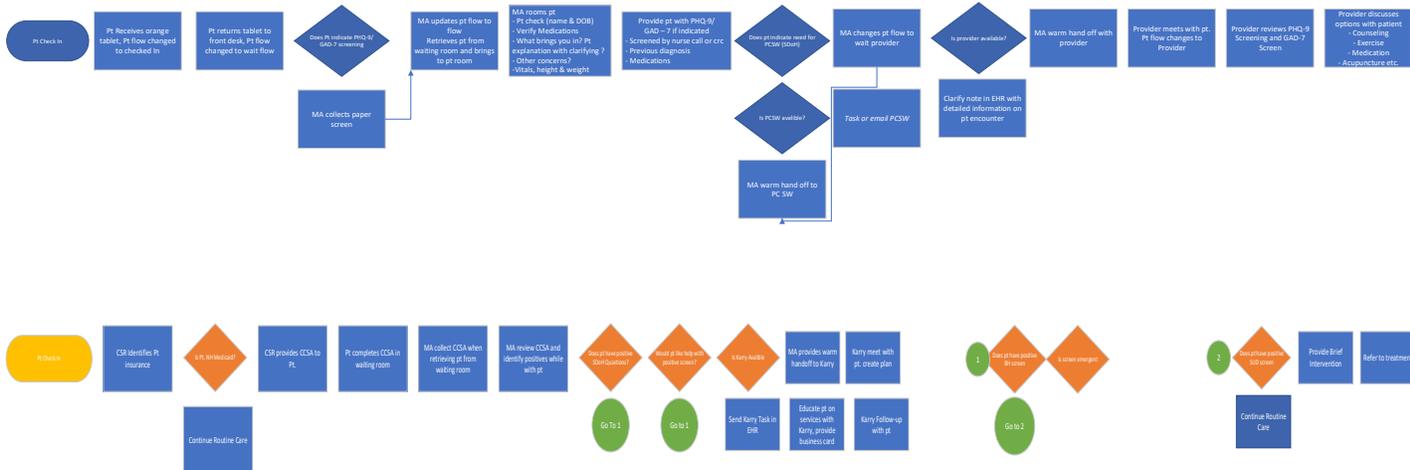
- The team identified two co-leads for the projects clinical advisement an MA and the practices Social worker.
- The project team began meeting bi-weekly in early fall, 2018 with support from many of the clinical leadership staff.
  - In early December, 2018 APD hired a business project manager who was tasked with an administrative support role for the B1 project. The involvement of this role has been very positive for the development and forward progression of the project work.

- The team has identified the need for a BHC to be embedded within the practice and is in recruit to hire activities for this position.
- The team has developed a robust work plan to target implementation and expansion by June, 2019. Example below: See full workplan in Appendix B1-2

Deliverable/Milestone	Task Assignments		PRE -Q1	Q1			Q1	Q2	Q3	Q4	Status
	Lead	Support	10/17-12/18	Jan, 2019	Feb, 2019	Mar, 2019	1/1/19-3/30/19	4/1/19-6/30/19	7/1/19-9/30/19	10/1/19-12/31/19	
IMPLEMENTATION YEAR ONE											
Meeting with QI facilitator & IDN leadership to launch project											Complete
Complete contracting process and submit											Complete
Create Psychiatry job description											Underway
Identify B1 work team members											Complete
Identify ongoing work team meeting dates/time											Complete
Meeting with APD team for introduction of project											Complete
Charter Completion- Final review and approval by all project team members											
<b>Team Meetings</b>											
Set up recurring bi-weekly meetings and support attendance across partner agencies											Complete
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps											
Set up recurring MDCT meetings monthly and case assessment process											
<b>Recruit to Hire</b>											
Document weekly progress toward position hiring and share with broader project team membership											
Share job descriptions and links to postings with all project team members											
Assign team member lead support for communication of progress and interview panel updates											
<b>Onboarding</b>											
Formalize and document the onboarding and training process for new positions											

Create a training plan by needed position to share and replicate for subsequent hires														
Address with project team onboarding activities to be supported by the IDN staff and partner network														
Training														

- To further map and track practice flow the CHI coach and IDN Program Director shadowed core practice staff for 2+hrs at each practice site creating time trials for patient rooming, visits, MA role and spaghetti diagrams modeling clinic flow will greatly support the development of sustainable clinic implementation plans.



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

Project Name, Lead	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
<b>Q1&amp;2: July 1- December 31<sup>st</sup>, 2018</b>						
<b>Alice Peck Day Memorial Hospital</b>	<i>Milestone 1</i> : Demonstrate Commitment from Primary Care Pilot Team	Self-Report	Met	Met	Met	Met
	<i>Milestone 2</i> : Develop Recurring Project Team Meeting	Share Project Team Membership List	Met			
	<i>Milestone 3</i> : Recruit to Hire Activities for All Open Positions	Share Job Posting, Follow up	Met			
	<i>Milestone 4</i> : Complete Formal Project Agreement between APD ,BH Support Agencies , and Community Support Agencies	Share Final Document	Met			

### CCSA

- The APD system is preparing for EPIC conversion in May, 2019 and incrementally onboarding to all of the DH Health System IT platforms.
- With this large scale shift within the organization the project team will be onboarding the CCSA on paper until late Spring and then shifting over to the EPIC embedded CCSA
- The current draft shared below;

**Alice Peck Day Memorial Hospital**  
A Dartmouth-Hitchcock Affiliate

Name:

MR#:

place patient sticker here

DOB:

Do you ever need help reading hospital materials?  Yes  No

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

If you checked off any problems how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<i>Check one</i>				

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<i>Check one</i>				

These questions refer to the last 12 months	No	Yes
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to?	0	1
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use?	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

How often do you have a drink containing alcohol?	
<input type="checkbox"/>	a. Never
<input type="checkbox"/>	b. Monthly or less
<input type="checkbox"/>	c. 2-4 times a month
<input type="checkbox"/>	d. 2-3 times a week
<input type="checkbox"/>	e. 4 or more times a week

How many standard drinks containing alcohol do you have in a particular day?	
<input type="checkbox"/>	a. 1 or 2
<input type="checkbox"/>	b. 3 or 4
<input type="checkbox"/>	c. 5 or 6
<input type="checkbox"/>	d. 7 to 9
<input type="checkbox"/>	e. 10 or more

How often do you have 6 or more drinks on one occasion?	
<input type="checkbox"/>	a. Never
<input type="checkbox"/>	b. Less than monthly
<input type="checkbox"/>	c. Monthly
<input type="checkbox"/>	d. Weekly
<input type="checkbox"/>	e. Daily or almost daily

\*Additional SDoH screenings not shared above

## MDCT/SCP

- The project team is reviewing current IDN team materials for MDCT flow and planning
- The team is meeting with IDN data supports in January to link the IT programs and clinical implantation. This will include training on the SCP.

## Timeline for Remaining Implementation

- The team plans to pilot test the CCSA in February 2019
- The team targets full spread of all CCD requirements by June, 2019

## Timeline for Remaining Implementation

- The team plans to pilot test the CCSA in February 2019
- The team targets full spread of all CCD requirements by June, 2019

## B1 Onboarding Support Partners:

## Phoenix House

- The IDN1 admin team met with Phoenix House (Keene), which provides outpatient and inpatient SUD treatment services, leadership in June, 2018 to review the most recent data on their population and address coordination with the B1 project. Given limited numbers of Medicaid members seen, and the spread of patients across the Keene and Dublin sites, the IDN1 admin team is still addressing coordinated involvement. Phoenix House is already aligned with MFS/CMC on a HRSA SUD grant, so it will be directly involved as a support for the B1 work as well. Additionally, as TAP21 screening is only being captured for those patients with payer of last resort (BDAS), the IDN1 team is working to develop a crosswalk to the CCSA, then follow up with PH’s clinical director to assess the feasibility of implementation and next steps.
  - Phoenix House continues to support the B1 project work in Cheshire County and submits reporting to the IDN regularly.
  - At this time PH is not looking to spread use of the CCSA.

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

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# Organizations Assessing Medicaid Members with the CCSA	9	1	2	4
# Organizations Contributing to and/or accessing Shared Care Plan	9	1	2	4
# Organizations Initiating Referrals to Supports	9	1	2	4
# Organizations Receiving Referrals to Supports	9	2	2	4
# of Organizations meeting requirements of “Coordinated Care Practice”	9	0	2	4
# of Organizations meeting requirements of “Integrated Care Practice”	4	0	0	2

#### Narrative addressing gaps in target for:

Narrative of Progress to Target	APD	CMC	NHC	DHP	MCH
# Organizations Assessing	APD has finalized	CMC has been	Newport Health Center	Dartmouth Health Psychiatry is	Monadnock Community

<p>Medicaid Members with the CCSA</p>	<p>their Adult CCSA and workflow. They are currently interviewing three candidates for their behavioral health clinician position. This position will be responsible for positive behavioral health responses of the workflow. They currently have an RN on staff who meet with SUD positive patients to support their participation in their MAT program, APD has established through a partnership with Headrest. They have finalized pathway follow-ups to positive SDoH responses on the CCSA as well as a</p>	<p>actively piloting the CCSA with their D team. Currently the team is discussing the use of MDCT with the shared care plan and how to best deploy that within their system.</p>	<p>has revised their final CCSA, workflow and pathways for SDoH positive follow-up with their newly on boarded community health worker. The current LCSW has in the past provided support for both BH and SDoH needs of patients and will transition over to supporting more BH needs as the CHW onboard, while still supporting cross coverage as needed. They are piloting a few patients, with the goal of full implementation in April on this year. On April 1st, they are holding an all provider meeting to train the rest of NHC staff on the CCSA and workflow for implementation with a goal to spread to the majority of providers by the complete of June 2019.</p>	<p>supporting the CCSA distribution in both the Heater Rd and GIM Clinics. Patients seen by the department will have received the CCSA in one of these clinics, or ensure their patients receive them in the primary care setting.</p>	<p>Hospital has finalized both their adult and pediatric CCSAs and identified two primary care clinics to pilot the CCD components (one family medicine, one pediatric) with the goal of implementing in May. They have reconfigured two internal resources specialist positions which primarily focused on financial support for patients to take on a community health worker role. They will receive training in June. They have hired two MSWs allowing them to readjust two positions from their behavioral health department. The readjustment will allow two MSWs to take on a BHC role in the primary care clinics, while the new position will take a more</p>
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	<p>data repository to house the responses to the CCSA. They are planning the final CCSA go live training for the staff next month for piloting. In May of this year they will be changing EHRs to Epic (edh) and have decided to deploy the CCSA in paper form.</p>				<p>traditional MSW role in the behavioral health department. The team is planning to complete the pathways and data repository for the CCSA results in the beginning of April, to allow input from all MSWs.</p>
<p># Organizations Contributing to and/or accessing Shared Care Plan</p>	<p>APD has received an initial training of the share care plan on the CMT platform. As they look forward to partner with outside behavioral health entities, they plan on utilizing the tool. Over the next month they will be building their flow and protocols with the</p>	<p>CMC is in ongoing conversation around the shared care plan and how to best utilize it within their system.</p>	<p>NHC has receive the initial training of the share care plan on the CMT platform. They will begin development of their protocols and process for the next month with the goal to go live in May. They have established partnerships with two community behavioral health entities which has also received the training.</p>	<p>Dartmouth Hitchcock Psych in partnership with DHMC - Heater Rd and GIM complete the shared care plan when appropriate patients are elevated to the level of need for the MDCT meeting.</p>	<p>MCH has been provided an introduction to the shared care plan and the utilization, and is planning to schedule a training once onboarding of pilot practices are better established.</p>

	goal to implement in July.		Together they will utilize the tool during the MDCT time.		
# Organizations Initiating Referrals to Supports	While APD is not initiating referrals as a result of the IDN work and CCSA follow-up, they do consistently make referrals to supports on an everyday basis. They have a CHW currently embedded in the primary care practices, which works with patients to support them in various SDoH needs. Primary care provides as well initiate referrals for patients if the need arises during the visit.		Newport Health Center has a newly hired CHW on staff who is currently working with patients as need arises during practice visits. They have also had a LCSW on staff who has consistently met this need in the past and is ongoing. As they fully implement the CCSA the pathways they have been will provide a more standardized approach to their referrals. They have also received support from their patient representative.	Dartmouth-Hitchcock supports patient needs as arise during visits by utilizing the many patient resources on staff. If the patient is crossed shared with primary care at Heater Rd or GIM then there is an internal dialog on coordination, sometime elevating to the MDCT meetings.	MCH has a behavioral health department embedded within their organization. In current state prior to CCSA implementation , primary care providers will alert MSWs when a service is needed for a patient. The MSW will either be schedule for an upcoming appointment or paged to the clinic in real time. These MSWs work with the patients in making referrals to support their needs.
# Organizations Receiving Referrals to Supports	The PC sites across the B1 projects are open to receipt of PC referrals as applicable	The PC sites across the B1 projects are open to receipt of PC referrals as applicable	NHC has a BHC and CHW on staff which have implemented pathways including follow-up to	The PC sites across the B1 projects are open to receipt of PC referrals as applicable from any project partner and BH site. . All PC sites	The PC sites across the B1 projects are open to receipt of PC referrals as applicable from any project partner

	from any project partner and BH site. All PC sites are using pathways to guide referrals.	from any project partner and BH site. . All PC sites are using pathways to guide referrals.	referrals made to ensure closed-loop referrals have been made. NHC has positive relationship with many of their community supports and are able to ensure follow-up has been initiated.	are using pathways to guide referrals.	and BH site. . All PC sites are using pathways to guide referrals.
# of Organizations meeting requirements of "Coordinated Care Practice"	APD is actively working on a bi-monthly meeting basis to implement the CCD components . They have finalized their CCSA and workflow. They are working on a training for staff to go live. They will begin to pilot the CCSA with one team next month and will actively work finalizing deliverables needed and building the structure to go live with		NHC has finalized a CCSA and workflow for their pediatric population. They have also completed the pathways for positive results, data repository for collecting results, and on boarded new staff to meet their need. They have begun implementing the CCSA and are working to complete materials and structure needed to start the MDCT meeting utilizing the charred care plan. They have two behavioral health	DHP is an active part of fulfilling the needs of the CCD requirements with in the DHMC system. They are consistently at the table for the active primary care teams standing up the CCD requirements and where appropriate take things on within their department to support the ongoing efforts.	MCH has finalized their CCSA for both their adult and pediatric populations. They are working to finalize the workflows and will be going live with their Jeffery and Pediatric practices by the end of June. They have begun building their structure needed for the MDCT meetings including use of the shared care plan with a goal to implement by the end of June.

	the MDCT and SCP the end of June.		organization which sit at the table to plan on a monthly bases. On April 1st they are presenting during the all provider meeting about the work they are doing and to initiate spread with the goal to complete spread within NHC by the end of June.		
# of Organizations meeting requirements of "Integrated Care Practice"	APD has a current MAT program in partnership with a local organization Headrest. They are currently in the process of hiring a BHC to help fulfill the acute behavioral health needs of their patients. They are also working on building partnerships with outside behavioral health organization to support the more chronic needs of		NHC will with the support of their BHC connect positive SUD screens with appropriate referrals out. Their BHC will also address the acuter behavioral health needs of their patients while partner with two outside behavioral health agencies to meet the more chronic needs. They have received an initial training of the CMT platform, and through New London are live with Event Notification.	DHP supports the patient needs of the DHMC system offering services in addition treatment including outpatient and intensive outpatient services. They also provide individual outpatient therapy, co-occurring therapy and psychiatric evaluation and psychopharmacology. They are an active part of the primary care MDCT meetings with input into the shared care plans as appropriate.	MCH has an embedded behavioral health department which offers services for depression, anxiety and substance use. Members of the team are available to meet with patient same day as their primary care appointment if they choose or will schedule a separate appointment. The project team has received an initial training on the CMT platform and are interested in moving forward with

<p>their patients, and helping to further collaborate primary care and behavioral health treatment. APD has received an initial training on the CMT platform and is currently live with the event notification portion. They look to further integrate the tool as they expand their partnerships with outside partners.</p>		<p>They are interested in moving forward to upload the physician champions Medicaid panel. They will plan to utilize the shared care plan functionality with their behavioral health partners.</p>		<p>uploading their Medicaid panel.</p>
--	--	--	--	--

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

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

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

Other involved partners are:

- Phoenix House
- Counseling Associates
- Headrest

#### 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.

In the July- December, 2018 term the last of the remaining B1 project participants began onboarding which, triggered the last wave of project hires and identification of staffing need. Outstanding positions to be hired are 1 BHC at APD, 2 CHW's at MCH, 1 CHW at VRH (partial IDN funding support), and potentially additional support for PM and CHW at NLH.

The numbers below are not reflective of pre-existing staff that are supporting IDN work without direct funding or for only partial allocation of staff time.

As of the July-December 31, 2018 term the IDN1 project portfolio is on track for full staffing as projected and the currently clinically implementing projects reflect as fully staffed and trained as projected. This excludes the fall, 2018 on boards of MCH, APD, NLH, CMC –Full PC panel, GIM for the current term.

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

In regard to staffing as the B1 projects expand from their initial implementation we anticipate targeting hiring and staffing allocations specifically to MAT that will be offset or supported by IDN funding. More information will be provided in upcoming reporting periods.

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











NLH/NHC:

[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							

Community Support Partner Budgets:

[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							



[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							
[REDACTED]							

## B1 All Project Budgets

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

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

*No significant changes made to the B1 budget guidance in the July-December, 2018 term. Updates are pending given any DHHS approved contingency planning submitted by IDN1.*



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

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

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

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

Name	Title	Organization	Sign Off Received (Y/N)
[REDACTED]	Practice Manager at Heater Road	Dartmouth Hitchcock Heater Rd. Practice	Y
[REDACTED]	Practice Manager at GIM	Dartmouth Hitchcock General Internal Medicine Practice	
[REDACTED]	Head of Psychiatry	Dartmouth Hitchcock Psychiatry	Y
[REDACTED]	CEO	West Central Behavioral Health	Y
[REDACTED]	Primary Care	Dartmouth Hitchcock Keene/Cheshire Medical Center Hospital Based Primary Care	Y
[REDACTED]	CEO	Monadnock Family Services	Y
[REDACTED]	Practice Manager	Alice Peck Day Hospital Based Primary Care Primary Care	Y
[REDACTED]	VP of Operations	New London Hospital and Medical Group Practice	Y
[REDACTED]		New London Pediatric Care	Y
[REDACTED]		Newport Health Center Practice	Y
[REDACTED]	Interim Director of	Valley Regional Hospital Primary Care Practice	Y

	Physician Practices		
	Partner	Counseling Associates	Y

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

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

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

For pediatric providers, the CCSA must also include:

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

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

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

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

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

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

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

f. Secure Messaging

g. Closed Loop Referrals

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

- Interactions between providers and community based organizations
- Timely communication

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

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



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

V1.0 June 2018

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

Last Updated 6/30/18

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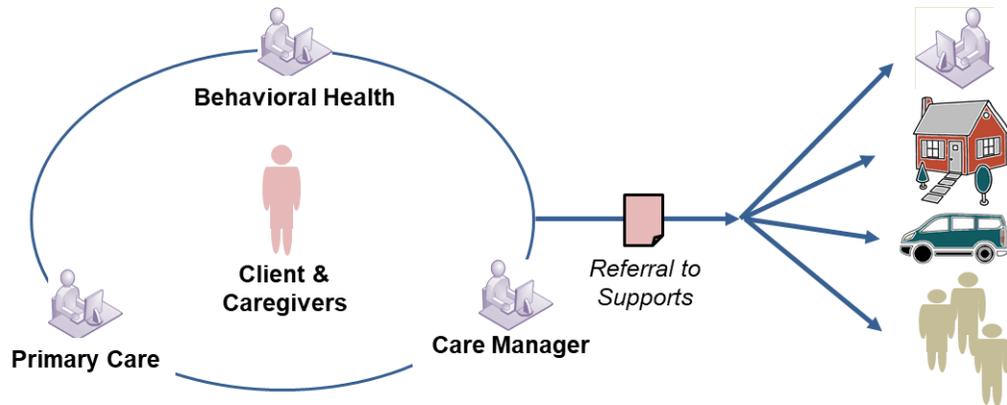
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**Version Change Log**

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

***Introduction***

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



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

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

The following Protocol will define the following:

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

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

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

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

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

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

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

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

"Office and Community Based Settings" exclude the hospital.

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

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

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

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

## Screening Domains and Questions

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

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

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

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

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

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

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

Table 2: IDN-1 Approved Alternate Screening Tools

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

## Domain 1: Demographics:

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

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

## Domain 2: Depression

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

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

Interpreting Results:

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

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<sup>1</sup> HL7 Patient Identification (PID) data fields, Health Level Seven Message Profiling Specification version 2.x. [www.HL7.org](http://www.HL7.org)

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

Table 3: PHQ-9 Example

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

## Domain 3: Substance Use

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

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

Interpreting Results:

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

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

Table 4: AUDIT Example

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

Table 5: DAST Example

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

## Domain 4: Medical

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

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

Interpreting Results:

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

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

- Kaiser Permanente, Your Current Life Situation Survey, questions 11 and 12
- PROMIS 10 question 1<sup>5</sup>
- DLA-20 question 1 “Health Practices” (clinician administered)<sup>6</sup>

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

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

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

## Domain 5: Housing

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

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

Interpreting Results:

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

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

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

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

## Domain 6: Family and Support Services (Social Isolation)

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

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

Interpreting Results:

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

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

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

## Domain 7: Education

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

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

Interpreting Results:

- “Yes” is positive and indicates education need

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

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

## Domain 8: Employment and Entitlements

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

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

Interpreting Results:

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

## Domain 9: Legal

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

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

Interpreting Results:

- “Yes” is positive and indicates Legal assistance need

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

<sup>11</sup> Dartmouth Hitchcock Social Determinants of Health screen

## Domain 10: Risk Assessment Including Suicide Risk

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

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

Interpreting Results:

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

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

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

Interpreting Results:

- 1 or greater is positive and indicates suicide risk

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

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

## Domain 11: Functional Status

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

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

Interpreting Results:

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

## Domain 12: Developmental and Behavioral Health screening (Pediatrics)

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

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

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

<sup>14</sup> American Academy of Pediatrics Bright Futures information may be found at AAP website:

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

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

## Response to Positive Screens

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

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

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

Table 6: Domains and Response Pathways for Positive Screens

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

## Response Pathway 1: Immediate Response

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



Protocols typically include the following:

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

## Response Pathway 2: Brief Intervention and Referral to Treatment

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



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

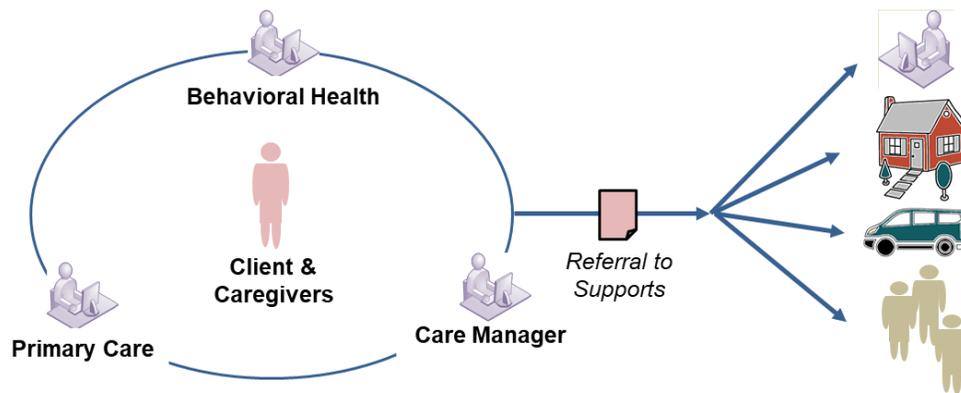
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<sup>15</sup> Substance Abuse and Mental Health Services Administration (SAMHSA) Screening, Brief Intervention, Referral to Treatment, <https://www.samhsa.gov/sbirt>

## Response Pathway 3: Brief Intervention and Referral to Supports

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

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



## Response Pathway 4: Enhanced Care Coordination

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

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

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

### **Demographics**

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

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

## Depression

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

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

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

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

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

## Substance Use – Alcohol

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

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

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

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

## Substance Use – Drugs

In the past 12 months...

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

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

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

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

## Medical

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

“Fair” and “Poor” are positive scores

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

## Housing

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

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

## Family & Support Services

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

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

## Education

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

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

## Employment and Entitlement

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

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

## Legal

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

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

## Risk assessment – Domestic Safety/Abuse

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

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

## Functional status

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

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

### B1.8a CCSA Utilization

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

CCSA Substitutes Approved as of 12/31/18:

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

The table below reflects utilization by organization as of 12/31/18. At the other B1 project team sites (CMC, MFS, VRH) the IDN team is supporting the rollout of the CSA process and building new clinical workflows around the process. **All B1 Project Teams represented below.**

CCSA Utilization Table													
Utilization July 1, 2018-December 31, 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	
<b>Providers</b>													
Alice Peck Day Primary Care	Paper Based CCSA set to Launch Winter, 2019: Pending Hiring												
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care	Domains Asked in Partners for Health Questionnaire to small Pilot Population							Full paper based CCSA set to launch in Winter, 2019: Pending Hiring					
Dartmouth-Hitchcock Heater Road Primary Care Practices	CCSA in Use												
Dartmouth Hitchcock General Internal Medicine	CCSA Pending Launch in Winter, 2019 : Pending Hiring												
Dartmouth-Hitchcock Psychiatry	CCSA in Use												
Monadnock Family Services	CCSA in Use												
Monadnock Community Hospital	Paper Based CCSA set to Launch Winter, 2019 : Pending Hiring												
Newport Health Center Practice	Paper Based CCSA set to Launch Winter, 2019 : Pending Hiring												
New London Hospital and Medical Group Practice and Pediatric Primary Care Practice	Pending Project Rollout												
Valley Regional Hospital Primary Care Practice	Paper Based CCSA in Use for Pilot Population effective Fall, 2018												
West Central Behavioral Helath	CCSA in Use												
Counseling Associates	CCSA Deployment- Ongoing												
Phoenix House	CCSA in Use												

### B1.8a Pediatric CCSA Utilization

Given the phased rollout of the B1 partners in IDN1, the implementation of the Pediatric CCSA is moving secondary to the Adult CCSA in most projects. IDN1 participated in discussions at D-H regarding the use of the Dartscreen as fulfillment of the required Pediatric CCSA domains, and used this work as the foundation to support development of IDN1 guidance for Pediatric and Adolescent screening. Newport Health Center and Monadnock Community Hospital have developed Adolescent and Pediatric screeners to be implemented. This is in process at Alice Peck Day and Valley Regional Hospital. **All B1 Project teams represented below.**

Pediatric Providers CCSA Utilization		
Utilization July 1, 2018-December 31, 2018		
	Validated Universal Screening: ASQ:3, and /or ASQ:SE at 9, 18, 24/30 month pediatric visits	Developmental Screening using brith futures or other American Academy of Pediatrics recognized development tools
Providers		
Alice Peck Day Primary Care	Anticipated utilization after Adult launch- Winter, 2019	
Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care	Y	Y
Dartmouth-Hitchcock Heater Road Primary Care Practices	Y	Y
Dartmouth Hitchcock General Internal Medicine	Anticipated utilization after Adult launch- Winter, 2019	
Dartmouth-Hitchcock Psychiatry	Y	Y
Monadnock Family Services	Y	Y
Newport Health Center Practice	Anticipated utilization launch- Winter, 2019	
New London Hospital and Medical Group Practice and Pediatric Primary Care Practice	Pending Project Rollout	
Valley Regional Hospital Primary Care Practice	Anticipated utilization launch- Winter, 2019	
West Central Behavioral Health	Y	Y
Counseling Associates	Pending Expansion	

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

Given the phased rollout of the B1 projects and varied implementation flow of each practice team the development of the MDCT across practices is continually in process. VRH, HRS, WCBH, MFS are underway with MDCT meetings.

- Given the unique structure of many of the project pilot teams including internal and external Behavioral Health supports, Substance Use disorder supports the MDCT members and monthly participation varies by case presentation and team structure. Many of the MDCT teams include multiple members from Behavioral Health and Primary Care. The grid below is up to date with designated representatives across project teams.

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

## B1-8c. Required Training

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

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

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

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

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

***No change to the IDN training strategy in the term of July-December, 2018. Through the strategy chosen by IDN1 all required trainings have been offered to applicable network partners and are either available on the IDN1 website or through recurring in person/webex based sessions.***

See table below for training status as of 12/31/18:

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

### B1-8d. Non Direct Care Staff Training

The Region 1 team has offered several web based trainings to all organization staff covering the domain areas listed below. Additionally, IDN 1 offers several slots to trainings hosted by other organizations and has hosted several trainings in the last semi-annual period. For all trainings that allow it these sessions are recorded and disseminated to all applicable organizations and staff through the Advisory Council list serve and posting on the IDN1 website.

If a provider expresses interest in expanded training, or requires additional information in any of the domain areas, the Region 1 IDN team will facilitate more robust either online or in-person. **Through the strategy chosen by IDN1 all required trainings have been offered to network partners and are either available on the IDN1 website or through recurring in person/webex based sessions.**

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
<b>Dartmouth-Hitchcock Heater Rd. South Primary Care Practice , Dartmouth Hitchcock Psychiatry, West Central Behavioral Health</b>										
Heater Rd Practice Team 1	Attained		Attained		Attained		Attained		Attained	
<b>Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services</b>										
Practice Team 1 Located at MFS	Attained		Attained		Attained		Attained		Attained	
Practice Team 2 - Pending	Pending Onboarding									
<b>Valley Regional Hospital Based Primary Care Practices and Counseling Associates</b>										
<b>Practice Team 1</b>	Attained		Attained		Attained		Attained		Attained	
Alice Peck Day Hospital Based Primary Care Practice	Offered		Offered		Offered		Offered		Offered	
New London Hospital and Medical Group Practice, Pediatric Care Practice	Offered		Offered		Offered		Offered		Offered	
Monadnock Hospital Primary Care-Peterborough Practice	Offered		Offered		Offered		Offered		Offered	
Newport Health Center Practice	Offered		Offered		Offered		Offered		Offered	
Dartmouth Hitchcock General Internal Medicine	Offered		Offered		Offered		Offered		Offered	

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

Please note that due to the current stage of project implementation there is no schedule for any provider team other than the DH/WCBH and VRH/CA Teams. Full MDCT schedules expected across the teams by end of February, 2019.

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

All B1 Project teams' schedules represented below.

	July 1, 2017- December 31, 2017	January 1, 2018-June 30, 2018	July 1, 2018- December 31, 2018
<b>Providers</b>			
<b>Dartmouth-Hitchcock Heater Rd. South Primary Care Practice , Dartmouth Hitchcock Psychiatry, West Central Behavioral Health</b>			
<i>Heater Rd Practice Team 1, 2, 3</i>	<b>Project Team Meeting:</b> 2nd, 4th Thursday	<b>Project Team Meeting:</b> 2nd, 4th Thursday , MDCT Meets 2nd Thursday	<b>Project Team Meeting:</b> 2nd, 4th Thursday , MDCT Meets 2nd Thursday
<b>Dartmouth Hitchcock Keene/Cheshire Medical Center Primary Care, Monadnock Family Services</b>			
<i>Practice Team 1</i>	Pre-Project Launch	<b>Project Team Meeting:</b> 1st, 3rd Wednesday	<b>Project Team Meeting:</b> 1st, 3rd Wednesday
<b>Valley Regional Hospital Based Primary Care Practices and Counseling Associates</b>			
<i>Practice Team 1</i>	<b>Full Project Team Meeting:</b> 2nd, 4th Tuesday , <b>Steering Committee Meeting:</b> 1st, 3rd Tuesday	<b>Full Project Team Meeting:</b> 2nd, 4th Tuesday , <b>Steering Committee Meeting:</b> 1st, 3rd Tuesday	<b>Full Project Team Meeting:</b> 2nd, 4th Tuesday , <b>Steering Committee Meeting:</b> 1st, 3rd Tuesday, MDCT 3rd Tuesday
<b>Alice Peck Day Hospital Based Primary Care Practice</b>	Pre-Project Launch	Pre-Project Launch	<b>Project Team Meeting:</b> 1st, 3rd Thursday
<b>New London Hospital and Medical Group Practice, Pediatric Care Practice, Newport Health Center Pediatric Practice</b>	Pre-Project Launch	Pre-Project Launch	<b>Project Team Meeting:</b> 2nd, 4th Friday
<b>Monadnock Hospital Primary Care- Peterborough Practice</b>	Pre-Project Launch	Pre-Project Launch	<b>Project Team Meeting:</b> 2nd, 4th Monday
<b>Dartmouth Hitchcock General Internal Medicine, Dartmouth Hitchcock Psychiatry, West Central Behavioral Health</b>			
<i>Practice Team 1</i>	Pre-Project Launch	Pre-Project Launch	<b>Project Team Meeting:</b> 2nd, 4th Tuesday

## 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, 2018, 4 of 4 IDN-1 Integrated Care Partners (West Central Behavioral Health, Dartmouth-Hitchcock Lebanon, Dartmouth-Hitchcock Psychiatry, Monadnock Community Hospital), and 6 of 7 IDN-1 Coordinated Care Partners (Valley Regional Hospital, Monadnock Family Services, Cheshire Medical Center / DH Clinic Keene, Counseling Associates, Alice Peck Day, New London Hospital / Newport Health Center Practice), are capable of exchanging Direct Secure Messages. The only partner not yet using Direct Messaging is Phoenix House. They engaged with the IDN project late in 2018 and is still using fax and phone for secure information exchange. Phoenix House has been informed of their options for Direct Messaging but opted to sequence implementation of quality reporting in 2018 and Direct Messaging in 2019.

In addition to the 11 organizations involved in integrated care projects, 10 community organizations (Crotched Mountain Community Care, Granite State Independent Living, Home Healthcare Hospice and Community Services, Lake Sunapee VNA, Monadnock Collaborative Claremont, Monadnock Collaborative Keene, Planned Parenthood of Northern New England – Claremont, Planned Parenthood of Northern New England – Keene, TLC Family Resource Center, and Visiting Nurse & Hospice of VT/NH) are capable of exchanging Direct Messages.

This represents 91% (10 of target 11) of Core Partners Capable of Exchanging Direct Secure Messages and 111% (10 of target 9) Community Partners Capable of Exchanging Direct Secure Messages.

*(Note that throughout 2018, IDN-1 focused strategy for project deployment. At the end of Q4 2018, IDN-1 made changes to the HIT project tracking to reflect the project changes. These included the ways partners are categorized for HIT projects and a subsequent reset of targets: HIT projects were reset based upon Partner categorization. 4 Integrated Care Partners and 7 Coordinated Care Partners focus on full technology implementations. Targets for Integrated Care and Coordinated Care Partners were reset to 11 across all technologies. Community Supports Partners focus on Direct Messaging for electronic referrals. Targets for Community Supports Partners were left unchanged at 9.)*

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

IDN1 released the following guidance as pertaining to Secure Messaging in the IDN1 B1 Protocols document:

### **Secure Messaging: Guidance Protocol**

*(Required for B1: Integrated Healthcare Project Partners)*

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

IDN-1 remains flexible with regards to Direct Messaging. Our overarching goal is to support inter-organizational communication for purposes of improved care coordination. We will continue to push Direct Messaging as our preferred technology.

- Use of legacy communication channels (e.g., Fax, Mail) are not ideal but acceptable to the IDN as long as communication and coordination are improving, and thus, positively impacting patient care.
- Use of emerging communication channels such as CommonWell and Carequality are expected to eventually supplant Direct Messaging as the preferred standard for electronic communication and we look forward to helping our partners evolve with improving technology as it matures in the market and among our Partners' EHR vendors.
- Use of 'cross-entity view' access (e.g., DH Connect) is sufficient for many clinical coordination use cases and the IDN will support this mode of secure communication.

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

### **Secure Messaging: Protocol Submission**

- If you are an IDN partner organization that is actively using Kno2 **there is no further information needed**
- If you are an IDN partner organization that is using another webmail application and are working directly with Mark Belanger and/or Jaime Dupuis **there is no further information needed**
- If your organization is using an alternate channel for secure communication with Partner organizations, and you have not engaged with the IDN previously around your process, please follow the steps below;
  - Submit a short 1 paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of use information to Jessica Powell at [Jessica.J.Powell@hitchcock.org](mailto:Jessica.J.Powell@hitchcock.org)

### **B1-8g. Closed Loop Referrals (CLRP)**

Guidance issued in the IDN1 B1 Protocols Document:

#### **Closed Loop Referrals: Guidance Protocol**

*(Required for B1: Integrated Healthcare Project Partners)*

IDN-1 Primary Care sites will interface with the Community Based Support Services organizations through a formal closed-loop referral process. The Care Team Coordinator or designated BH or CHW support staff will be the accountable member of the Integrated Care Team in all communications with the Community

Based Support Services. Upon identification of a need for community support services by the Integrated Care Team, the Care Team Coordinator will begin the referral to supports process.

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

- NH Alcohol and Drug Treatment Locator (<http://nhtreatment.org/>)
- Refer Web - Servicelink Community Resource Directory (<http://www.referweb.net/nhsl/>)
- NH Easy – Gateway to Services (<https://nheasy.nh.gov/#/>)
- NH Peer Support by region: (<http://www.dhhs.nh.gov/dcbcs/bbh/peer.htm>)
- 2-1-1 New Hampshire and <http://www.homehelpnh.org/> for housing assistance
- Monadnock Regional Council for Community Transportation (<http://monadnockrcc.weebly.com/need-a-ride.html>) (other regions <https://www.nh.gov/dot/programs/scc/rcc.htm>)
- (pending pilot) UniteUs community support organization directory.

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

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

### **Closed Loop Referral: Protocol Submission**

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

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

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

### **Interactions between Providers and Community Based Organizations: Guidance Protocol**

*(Required for B1: Integrated Healthcare Project Partners)*

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

**Population to be served:**

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

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

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

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

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

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

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

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

## **Shared Care Plan: Guidance Protocol**

*(Required for B1: Integrated Healthcare Project Partners)*

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

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

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

- For organizations not yet ready to use a web-based platform for shared care planning the IDN1 team will provide a paper version of the SCP fields
- Additionally, the IDN1 team will work with your organization and partners to progress readiness to the CMT tool.
- For partner organizations that follow the Cherokee Health pattern (e.g., The partner organization provides both primary care and behavioral health services, the organization integrates care

internally, and there are no other organizations present in the sub-region that provide care to a significant number of Medicaid members) it is acceptable to share the care plan within a single EHR rather than a shared technology platform. IDN-1 encourages, but does not require, use of the CMT technology platform on top of the sharing that occurs in the Partner’s EHR.

Pre-SCP Use:

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

SCP Use:

The minimum standard for IDN1 guidance states:

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

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

**Shared Care Plan: Protocol Submission**

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

**Timely Communication: Guidance Protocol**

*(Required for B1: Integrated Healthcare Project Partners)*

Action	Timing
Capture (or Update) EHR and Shared Care plan application (CMT) with Care Plan	Within 1 business days of integrated core team shared care meeting.

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

[See the Closed Loop Referral: Guidance Protocol](#)

- Referral Type - Based on urgency of care required, the referral can be marked as:
  - Urgent Referral – immediate referral per phone
  - Priority Referral – Referrals that require the patient to be seen within 3-14 days (from referral sent to patient seen)
  - Routine Referral – Referrals that require the patient/client to be seen within 28 days (from referral sent to patient seen)

## Timely Communication: Protocol Submission

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

## Privacy: Guidance Protocol

*(Required for B1: Integrated Healthcare Project Partners)*

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

IDN1 is offering its Partners the following support to implement privacy protections for purposes of inter-organizational shared care planning and for evaluation/quality reporting:

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

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

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

- Ability to protect electronically-exchanged data in a secure and confidential manner meeting all applicable State and Federal privacy and security laws (e.g., HIPAA, 42 CFR Part 2).
- Ability for additional disclosures of patient identifying information, with patient consent, to facilitate payment and healthcare operations such as claims management, quality assessment, and patient safety activities.

- Ability for additional disclosures of patient identifying information to certain contractors, subcontractors, and legal representatives for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation.
- Ability for permitting use of an abbreviated notice of prohibition on re-disclosure more easily accommodated in EHR text fields for users of electronic health records (EHRs).

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

## **Case Management Coordination: Guidance Protocol**

*(Required for B1: Integrated Healthcare Project Partners)*

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

For B1 Project Partners: the Care Team Coordinator will be accountable for case manager coordination. She/he will determine the case management resources that are to be part of the integrated core team and the case managers who are to be kept informed of the shared care plan.

See the guidelines below to manage shared patients:

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

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

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

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

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

See table below with care team agreement and role delineation;

### ***Mutual Agreement***

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

### ***Expectations***

#### Primary Care

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

#### Behavioral Health

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

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

Guidance above taken from:

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

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

*(Required for B1: Integrated Healthcare Project Partners)*

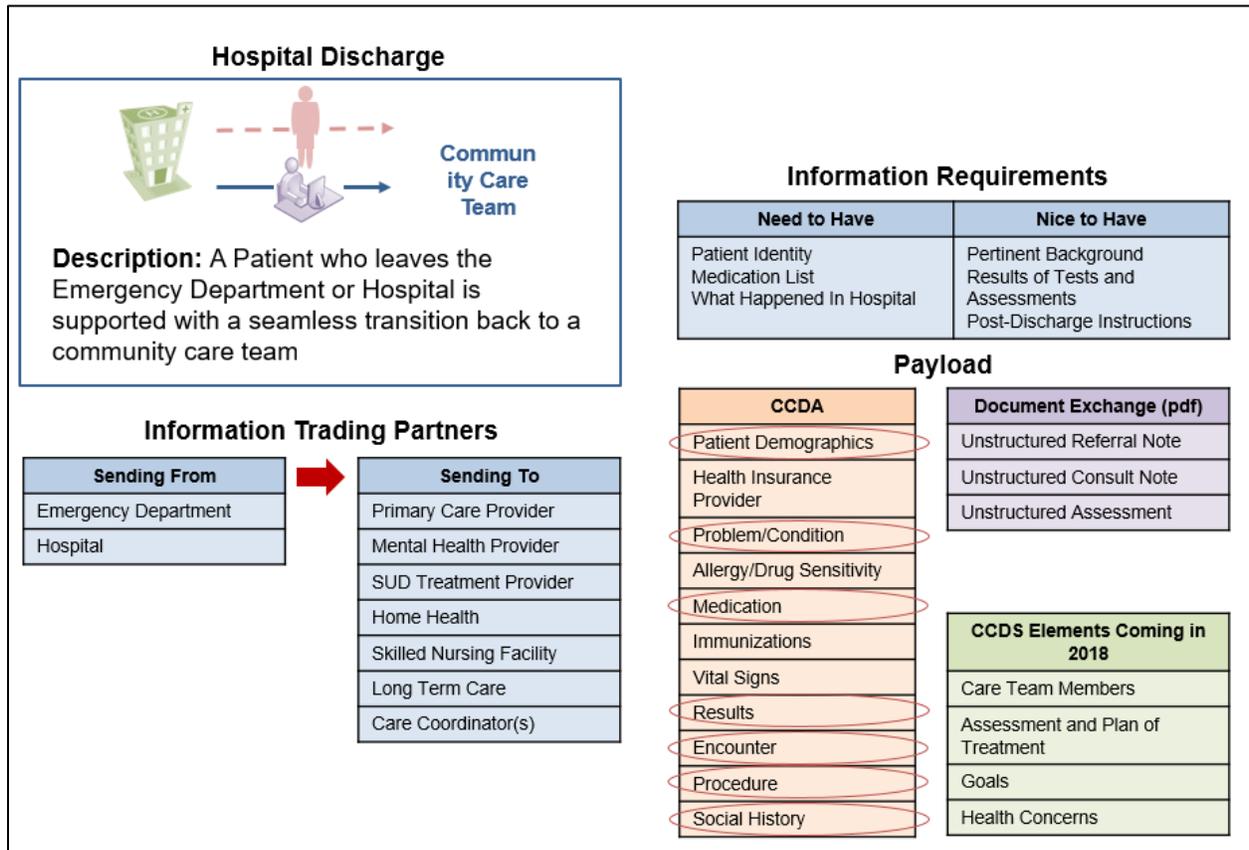
IDN1 has implemented workflows with network partners to facilitate safe transitions from institutional settings back to primary care, behavioral health, and social support service providers. For a specific workflow request please contact the IDN1 Admin Team.

Priority Information to Support Transitions:

- Current medication list – to enable medication reconciliation among all post-acute care providers and to prevent medication based adverse events.
- Recent history of what happened during the hospitalization, any new problems discovered, any procedures undergone, and any new history discovered.

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

See Graphic below for guidance on Hospital Discharge Workflow:



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

- **Timely** - Patients receive needed transitions and consultative services without unnecessary delays.
- **Safe** - Referrals and transitions are planned and managed to prevent harm to patients from medical or administrative errors.
- **Effective** - Referrals and transitions are based on scientific knowledge, and executed well to maximize their benefit.
- **Patient-centered** - Referrals and transitions are responsive to patient and family needs and preferences.
- **Efficient** - Referrals and transitions are limited to those that are likely to benefit patients, and avoid unnecessary duplication of services.
- **Equitable** - The availability and quality of referrals and transitions does not vary by the personal characteristics of patients.

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



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

**Intake Procedures: Protocol Submission**

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

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

*(Required for B1: Integrated Healthcare Project Partners)*

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

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

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

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

- NH Board of Medicine Resources: <https://www.oplc.nh.gov/medicine/opioid-prescribing.htm>
- Final Rule: PART Med 502 Opioid Prescribing:  
<https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf>  
[https://www.nhms.org/sites/default/files/Pdfs/NH\\_BOM\\_opioid\\_rules\\_11-2-16.pdf](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](https://www.nhms.org/sites/default/files/Pdfs/1-4-17Opioid_Patient_Checklist_Med_502_Opioid_Prescribing_Rules.pdf)
- New Hampshire Opioid Prescribing Resources from the NH Medical Society:  
<https://www.nhms.org/resources/opioid>
- Opioid Dose Calculator from the Agency Medical Directors' Group:  
<http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>

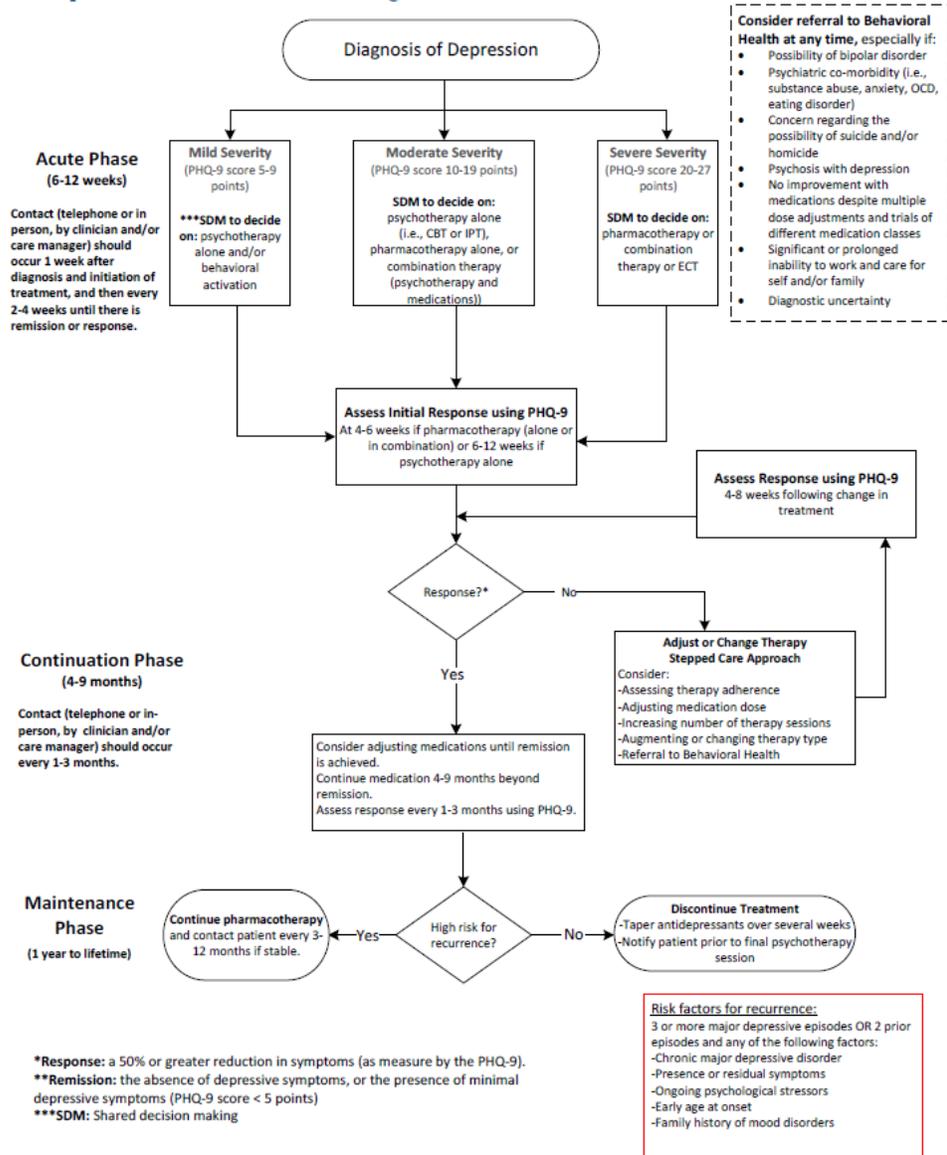
### **Adherence to NH Board of Medicine Guidelines on Opioid Use: Protocol Submission**

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

### **Treatment of Mild to Moderate Depression: Guidance Protocol**

*(Required for B1: Integrated Healthcare Project Partners)*

## Depression Treatment in Adults Algorithm



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

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

## Event Notifications: Guidance Protocol

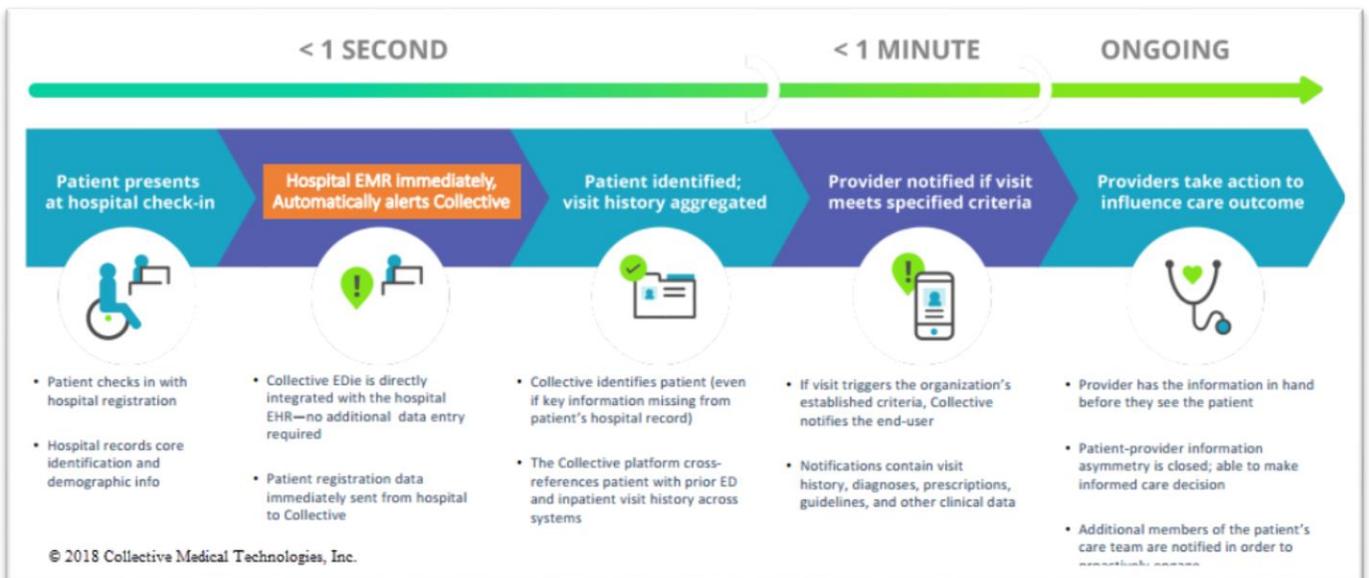
*(Required for B1: Integrated Healthcare Project Partners)*

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

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

### Pre-ENS Use:

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



### Privacy:

- Basic use of ENS to monitor a broad-base of Medicaid patients is acceptable and does not require the patient to provide consent.
- The relationship between the provider organization and the patient is not revealed unless that same patient is also involved in a B1 project for Shared Care Planning with CMT. In those instances:

- All necessary privacy protections are in place including updates to patient privacy documentation and forms, scripts for explaining SCP to patients, and consent forms where required by law.

#### ENS Use:

- IDN1 will facilitate a training session with CMT to discuss best practices, workflows and additional reporting capabilities if needed to support projects as needed. Examples Include:
  - Review Census reports regularly for any events you may not have been aware of;
  - Monitor ED Utilizations reports for ED frequency or travelling around to different ED's;

## **Event Notifications: Protocol Submission**

- If you are an IDN partner organization involved with a B1: Integrated Healthcare project that is actively using the CMT Event Notification Service and your process has been reviewed with your project team **there is no further information needed**
- If your organization is enabled with CMT but the ENS is not yet in use and you are actively meeting with the IDN1 B1 or any Community-Based project team **there is no further information needed**
- If your organization is using an alternate process for ENS, not using the CMT technology, and you have previously reviewed this with the IDN1 team **there is no further information needed**
- If your organization is using an alternative process for Event Notification Services and you have not engaged with the IDN previously around your process please follow the steps below:
  - Submit a short 1 paragraph narrative regarding your organization process, tools used, level of information being shared, frequency of use information to Jessica Powell at [Jessica.J.Powell@hitchcock.org](mailto:Jessica.J.Powell@hitchcock.org)

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: <ul style="list-style-type: none"> <li>Demographic information</li> <li>Physical health review</li> <li>Substance use review</li> <li>Housing assessment</li> <li>Family and support services</li> </ul>	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"> <li>• Educational attainment</li> <li>• Employment or entitlement</li> <li>• Access to legal services</li> <li>• Suicide risk assessment</li> <li>• Functional status assessment</li> <li>• Universal screening using depression screening (PHQ 2 &amp; 9) and</li> <li>• Universal screening using SBIRT</li> </ul>					
	<p>For pediatric providers, the CCSA must also include:</p> <ul style="list-style-type: none"> <li>• Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits;</li> <li>• Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental</li> </ul>	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"> <li>• PCPs</li> <li>• Behavioral health providers (including a psychiatrist)</li> <li>• Assigned care managers or community health worker</li> </ul>	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	Multi-disciplinary core team training for service	Training schedule				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<p>providers on topics that includes, at minimum:</p> <ul style="list-style-type: none"> <li>• Diabetes hyperglycemia</li> <li>• Dyslipidemia</li> <li>• Hypertension</li> <li>• Mental health topics (multiple)</li> <li>• SUD topics (multiple)</li> </ul>	<p>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 for each training</p>				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and	Training schedule and table listing all				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	beliefs about mental disorders that can aid in recognition and management	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"> <li>• Interactions between providers and community based organizations</li> <li>• Timely communication</li> <li>• Privacy, including limitations on information for communications with treating provider and community based organizations</li> <li>• Coordination among case managers (internal and external to IDN)</li> <li>• Safe transitions from institutional settings back to primary care, behavioral health and social support service providers</li> <li>• Intake procedures that include systematically soliciting patient consent to confidentially share</li> </ul>	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
	information among providers <ul style="list-style-type: none"> <li>Adherence to NH Board of Medicine guidelines on opioid prescribing</li> </ul>					

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

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

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

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

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

*See B1-3, B1-10 for additional information on CCD attainment across project teams*

## B1-9b. MAT

*Updates as of December 31, 2018:*

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

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

[Redacted text block]

B1-9c. HIT: See tables below:

Organization	Use of Technology to Identify at Risk Patients – May Include: –EHR System –Pre-Manage –Quality Data Center –MCO Data	Use of Technology to Plan Care – May Include: –EHR System –Pre-Manage	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
<b>Integrated Care and Coordinated Care Partners</b>				
West Central Behavioral Health	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: Yes	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: Yes
Dartmouth-Hitchcock Clinic Lebanon	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: Yes Other Referral Method: Yes
Dartmouth-Hitchcock Psychiatric Associates	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: Yes Other Referral Method: Yes
Monadnock Community Hospital	EHR System: Yes Pre-Manage: 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: Yes
Valley Regional Hospital, Valley Family Physicians	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: Yes
Monadnock Family Services	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: Yes
Cheshire Medical Center – Primary Care	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: Yes	EHR System: Yes Pre-Manage: Yes Quality Data Center: Yes	Direct Secure Messaging: Yes CommonWell/Carequality: Yes Other Referral Method: Yes
Counseling Associates	EHR System: Yes Pre-Manage: 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: Yes
Alice Peck Day 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: Yes
New London Hospital	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: Yes
Phoenix House	EHR System: Yes Pre-Manage: No Quality Data Center: Yes MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No Quality Data Center: Yes	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: Yes

<b>Community Supports Partners</b>				
Crotched Mountain Community Care	Electronic Data System: Yes Pre-Manage: Yes	Electronic Data System: Yes Pre-Manage: Yes	Electronic Data System: Yes Pre-Manage: Yes	Direct Secure Messaging: Yes Other Referral Method: Yes
Headrest	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: No Other Referral Method: Yes
Southwestern Community Services	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: No Other Referral Method: Yes
Child and Family Services	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: No Other Referral Method: Yes
TLC Family Resource Center	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Electronic Data System: Yes Pre-Manage: No	Direct Secure Messaging: Yes CommonWell/Carequality: No Other Referral Method: Yes
<b>Other Partners</b>				
New Hampshire Hospital	EHR System: Yes Pre-Manage: No MCO Data: No	EHR System: Yes Pre-Manage: No	EHR System: Yes Pre-Manage: No	Direct Secure Messaging: No CommonWell/Carequality: No Other Referral Method: Yes
<b>Key:</b>				
Little or no IT capability to support the function.				
Some siloed (single organization) IT capability to support the function.				
Multi-organization IT capability in place to support the function.				

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

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

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

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

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

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

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

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

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

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

Care plans are informed by:

Patient medical records housed in the EHRs

Patient Goals – housed in the EHRs and Shared Care Plan

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

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

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

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

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

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

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

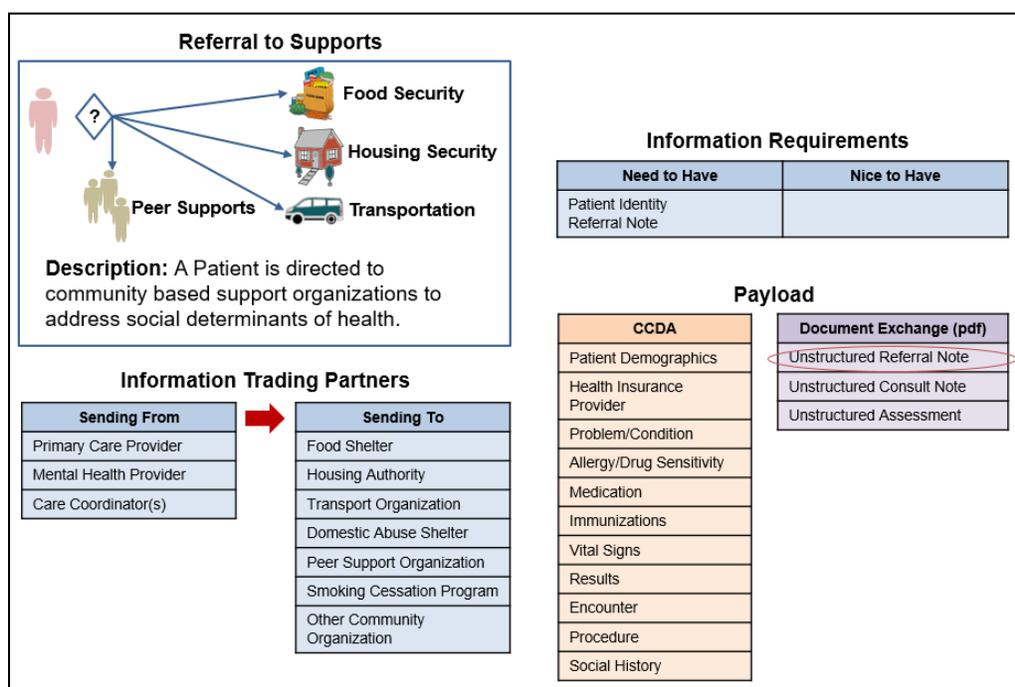
## B1-9d. Joint Service Protocols and Communication Channels

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

### Referral to Supports

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

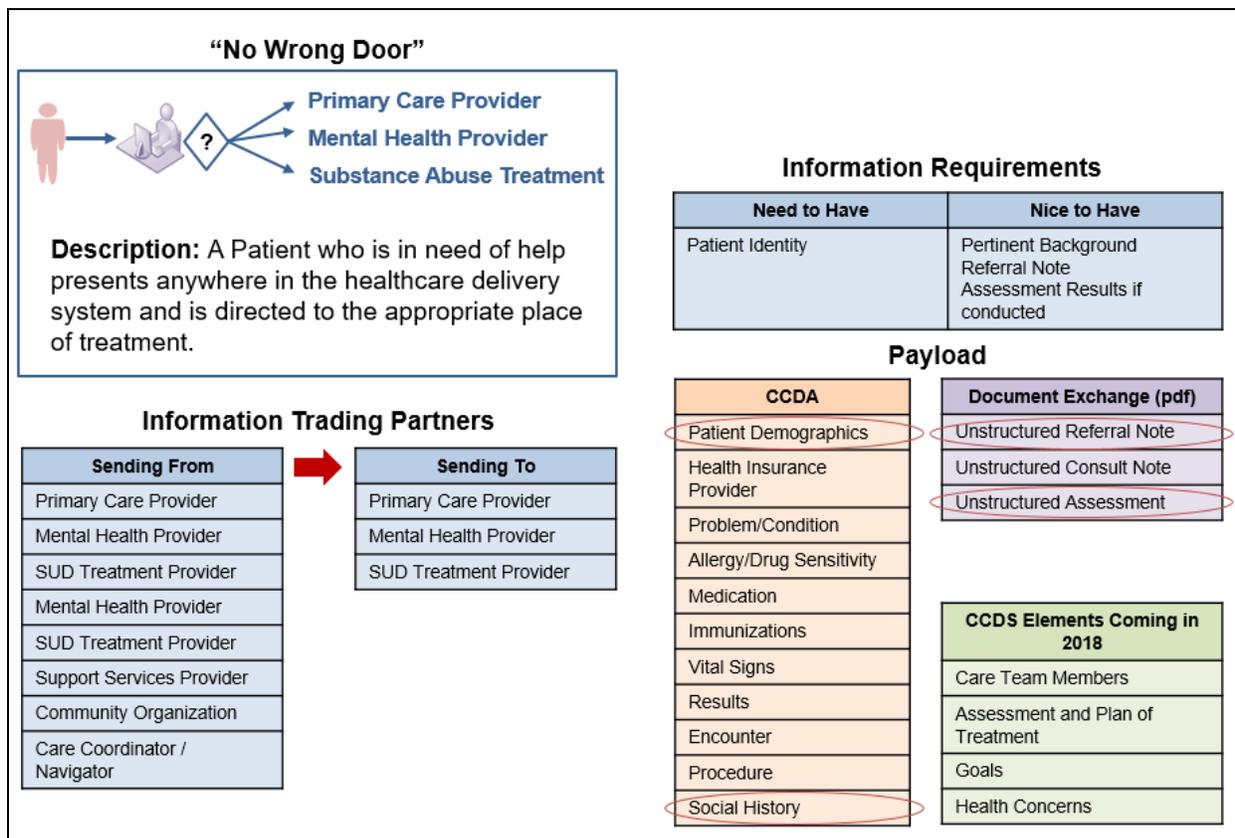
Figure 12: Referral to Supports Workflows



### “No Wrong Door”

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

Figure 13: “No Wrong Door” Workflows



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

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

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

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

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

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

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

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

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

All project components up to date in grids below.

Achieved	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	10 Included: APD, CMC, CFS, CA, MFS, NLH/NHC, Phoenix House, VRH, Headrest, Mascoma CHC	0	1	2	3
Integrated Care Practice	4 Included: WCBH, D-H Leb., D-H Psychiatry, MCH	0	0	2	3

Use the format below to identify practices that have **achieved** Coordinated Care Practice or Integrated Care Practice designation during this reporting period.

Please note the achieved status of the organizations listed in the table below only pertains to the project team pilot group. It does not indicate full spread of all project components across the entire organization or all subcomponent practices.

Progress Toward Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18

	Counseling Associates	<ul style="list-style-type: none"> <li>• Came onboard with IDN1 as a B1 partner</li> <li>• Signed Subcontract with VRH for B1 project support</li> </ul>	<ul style="list-style-type: none"> <li>• Project team meetings with VRH B1 team</li> <li>• Conversations for B1 support with NLH/NHC project team</li> </ul>	<ul style="list-style-type: none"> <li>• CCSA in use</li> <li>• Participation in project team, MDCT at VRH</li> <li>• Ongoing collaboration with NHC and pending MDCT participation</li> <li>• IDN reporting</li> </ul>
	Monadnock Family Services	<ul style="list-style-type: none"> <li>• Partner proposal with CMC for B1 RFP in July, 2017</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in monthly B1 project team meetings</li> </ul>	<ul style="list-style-type: none"> <li>• CCSA in use</li> <li>• Enabled use of SCP</li> <li>• Participation in monthly B1 project team meetings</li> <li>• Clinical space established</li> <li>• Information sessions held with clients regarding new PC services on site</li> <li>• IDN reporting</li> </ul>
	New London Hospital/Newport Health Center	<ul style="list-style-type: none"> <li>• 2 Meetings held with IDN Admin. team to discuss next steps for B1 Involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing work with IDN1 Admin. team to develop RFP details, Project framework and draft SOW for Subcontract</li> </ul>	<ul style="list-style-type: none"> <li>• Contract signed for all practice teams</li> <li>• Bi-weekly meetings underway with NHC project team</li> <li>• CCSA developed and in use across pilot team</li> <li>• SCP enabled and in use for the pilot population</li> <li>• MDCT schedule established and first month complete</li> <li>• IDN reporting</li> </ul>
	Valley Regional Hospital	<ul style="list-style-type: none"> <li>• Submission of B1 RFP and Project Launch</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing bi-weekly meetings and pre-implementation infrastructure</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing bi-weekly meetings</li> <li>• Monthly MDCT underway and including CA, WCBH</li> </ul>

			development for Fall patient deployment	<ul style="list-style-type: none"> <li>• Use of SCP</li> <li>• Use of all B1 protocols</li> <li>• Use of CCSA in place and screening across 2 providers- capturing 20%</li> <li>• Continued spread to all VPC providers</li> </ul>
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Use the format below to identify the **progress** each practice made toward Coordinated Care Practice or Integrated Care Practice designation during this reporting period.

Progress Toward Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	6	1	6	6
	Alice Peck Day Memorial Hospital	<ul style="list-style-type: none"> <li>• Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing meetings with IDN1 leadership to determine B1 project launch and RFP</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly project team meetings with clinical, administrative and IDN team membership</li> <li>• Recruit to hire for clinical positions</li> <li>• CCSA vetting underway</li> <li>• MDCT workflows underway</li> <li>• SCP in process</li> <li>• IDN reporting</li> </ul>
	Cheshire Medical Center/DHK	<ul style="list-style-type: none"> <li>• Submitted Project Proposal with MFS in July, 2017 B1 RFP</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly project team meetings with clinical, administrative and IDN team membership</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly project team meetings with clinical, administrative and IDN team membership</li> <li>• APRN Hired</li> </ul>

		<ul style="list-style-type: none"> <li>On hold until transitions within PC are Complete</li> </ul>	<ul style="list-style-type: none"> <li>Recruit to hire for clinical positions</li> <li>Progress underway for retrofitting the clinical space at MFS</li> <li>QI activities and facilitation provided by CHI</li> </ul>	<ul style="list-style-type: none"> <li>Clinical space completed at MFS</li> <li>Training underway for APRN, RN, and Admin. supports</li> <li>QI activities and facilitation provided by CHI</li> <li>Pending launch of MDCT, SCP</li> <li>Pending launch of CCSA across all PC</li> <li>CCSA on paper underway and with 70+ patients screened</li> <li>IDN reporting</li> </ul>
	Child and Family Services	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> <li>Name change to Waypoint</li> <li>Support of Upper Valley B1 projects pending</li> </ul>
	Phoenix House	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> <li>Support of CMC SUD initiatives and coordination for B1</li> </ul>	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> <li>Use of internal TAP21 for CCSA</li> <li>IDN reporting</li> <li>Support in of CMC SUD initiatives and coordination for B1</li> </ul>
	Headrest	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> <li>Support of DH-HRS SUD initiatives and participation with B1 MDCT underway</li> </ul>	<ul style="list-style-type: none"> <li>Engagement in MDCT, SCP usage with HRS team</li> <li>Participation in all IDN1 partner events</li> </ul>

	Mascoma Community Health Center	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>Given less than 100 Medicaid members being served IDN1 in agreement with DHHS will not pursue further for CCD attainment</li> </ul>
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Progress Toward Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
	4	0	2	3
	West Central Behavioral Health	<ul style="list-style-type: none"> <li>Onboard with Project Planning</li> <li>Participation at all IDN1 all partner events</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing bi-weekly meetings and implementation of CCSA</li> <li>Participation in MDCT, SCP</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing bi-weekly meetings and implementation of CCSA</li> <li>Participation in MDCT, SCP</li> <li>IDN reporting</li> </ul>
	D-H Primary Care: Lebanon Based	<ul style="list-style-type: none"> <li>Onboard with Project Planning</li> <li>Participation at all IDN1 all partner events</li> <li>Recruit to hire for CTC position</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing bi-weekly meetings and implementation of SDoH Screener</li> <li>Participation in MDCT, SCP</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing bi-weekly meetings and implementation of CCSA</li> <li>Participation in MDCT, SCP</li> <li>IDN reporting</li> </ul>
	Monadnock Community Hospital	<ul style="list-style-type: none"> <li>Participation at IDN1 All partner events</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing work with IDN1 Admin. team to develop RFP details, Project framework and</li> </ul>	<ul style="list-style-type: none"> <li>Monthly project team meetings with clinical, administrative and IDN team membership</li> </ul>

			draft SOW for Subcontract	<ul style="list-style-type: none"> <li>Recruit to hire for clinical positions</li> <li>CCSA vetting underway</li> <li>MDCT workflows underway</li> <li>SCP in process</li> </ul> IDN reporting
	D-H Psychiatry	<ul style="list-style-type: none"> <li>Onboard with Project Planning</li> <li>Participation at all IDN1 all partner events</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing bi-weekly meetings and implementation of CCSA</li> <li>Participation in MDCT, SCP</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing bi-weekly meetings</li> <li>Participation in MDCT, SCP</li> <li>IDN reporting</li> </ul>

## Projects C: Care Transitions-Focused

### IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

*See Appendix C-1 for Excel Workplan of C1 Activities*

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

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

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

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

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

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

#### Updates as of 12/31/18:

Given the ongoing funding uncertainties within the DSRIP program statewide the Region 1 administrative team in early winter 2018 brought a recommendation to the executive committee to hold on the release of RFP's for community projects. The group voted to carry out a hold on all new project execution and to review once funding clarity had been reached. As of 12/31/18 significant progress has been made to ensure the continuation of the DSRIP waiver in NH but funding was still largely uncertain. At this point in the waivers implementation term the IDN1 team is requesting in contingency planning with DHHS that an allowance is made for no continued spread of scale of community projects. Thus, allowing the IDN team to consolidate resources to the B1 projects and workforce efforts while continuing to support and work on sustainability plans for the existing C, D, and E projects.

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

Monadnock Family Services (MFS), the Monadnock Collaborative (MC), and Cheshire Medical Center/Dartmouth Hitchcock (CMC/DH) are the three lead partners for the Co-Pilot project. This project combines implementation efforts for Enhanced Care Coordination and Care Transitions into one project that accomplishes all of the goals of the ECC and CTI work in the Monadnock sub-region of the IDN. As a

collaborative team, they build upon the successful partnership between CMC/DH and MC, the local Service Link Resource Center (SL), where a coordinated care transition program for high acuity patients has been in operation for several years, adding the community behavioral health perspective and expertise well-established at MFS.

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

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

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

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

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

The targeted population for this project will be (1) adults living in the Monadnock Region who currently have Medicaid insurance or are Medicaid eligible, have a behavioral health diagnosis, who have experienced multiple emergency room visits or inpatient hospitalizations at Cheshire Medical Center or New Hampshire Hospital and/or also have a co-occurring long term physical health problems and/or significant barriers to successfully living in the community (i.e.: homelessness, unstable community tenure,

etc.) and (2) children less than 18 years of age living with a serious emotional disturbance, particularly those with other significant family challenges regarding SDOH.

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

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

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

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

Co-Pilot will provide CTI for the Care Transitions component of this project and incorporate the enhanced care coordination as a warm hand-off to CTI participants who do not qualify for pre-existing MFS services. This project demonstrates the collaboration with other community partners- including all organizations within the region that serve the targeted population, to ensure increased quality of life and decreased repeated utilization of NHH, CMC/DH emergency department and inpatient stay. The proposed services include: a system for how MFS, MC, CMC/DH and NHH will communicate and coordinate to develop an effective workflow; development of referral process; implementation of the three phases of the CTI model; implementation of the enhanced care coordination model; and consistent monitoring of metrics before, during, and after CTI and enhanced care coordination services are provided. The administrative oversight

for implementation of this project rests with MFS, who will provide staffing supports to ensure administrative aspects of this project are completed.

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

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

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

### Updates for Co-Pilot July- December, 2018:

The Co-Pilot coordinated project supported by Monadnock Family Services, Monadnock Collaborative, and Cheshire Medical Center blends the project components of the C1: Care Transitions and E5: Enhanced Care Coordination projects. In the term of July-December, 2018 the project team met biweekly to work through patient flows, project referral and process development. Additionally, the clinical team meets 2x weekly to review current cases and for team supervision.

After 6+ months of operational clinical implementation the summer and fall of 2018 allowed the team to target materials development and work to refine the processes in place for referral flow, client management through PDSA.

This term also brought significant staff transitions to the small team which, was needed to shake up some of the roles and bring more structure to the CTI components of the project but did have an impact on the uptake of new referrals. The team saw a gap in new Phase I clients through early fall, 2018.

Current staffing allocation has 2FTE Coordinators for ECC, 2 FTE Coordinators for CTI, a 1 FTE Referral Coordinator and a clinical advisor. The previous model had the referral coordinator serve for both CTI and ECC referrals while spending 50% of her time on site at D-HK/CMC. Given a staff change for this position that process has been restructured. There is still staff presence at CMC but it is a new role and not completely designated to referrals for both treatment streams. The team continues to find new ways to coordinate with CMC, generate program information and awareness about eligibility. The team has created a new intake form which is more robust and captures a strong baseline for well-being at point of program entry. See below for the form in use:



Client Name: _____		Date: _____	
Client is a resident of Monadnock Region, has Medicaid, and is over 18 _____		Medicaid #: _____	
Street Address: _____			
City: _____		State: _____ Zip: _____	
SSN: _____	DOB: _____	Age: _____	Preferred Gender Identification (M/F/Other): _____
Home Phone: _____		Work Phone: _____	
Emergency Contact Person: _____		Alternate Emergency Contact Person: _____	
Caller Name & Relationship: _____		Caller Phone: _____	
Has Complex Medical Needs: _____		Referred by: _____	
Client has Behavioral Concerns: <input type="checkbox"/> Yes <input type="checkbox"/> No		Services Requested: <input type="checkbox"/> Enhanced Care Coordination <input type="checkbox"/> CUI <input type="checkbox"/>	
Family Members and/or significant people in the person's life: _____			
Legal Guardians: _____			
Key Pages: _____			
Referral by: _____ Reason for referral and desired outcome according to referral source: _____			
Date of First Contact: _____			
Identifying information, presenting concerns, desired outcome of services from the perspective of the person referred: _____			
<b>Physical Health</b>			
Health diagnosis (include all that apply): _____		Current Medical Providers: _____	
		Address and phone numbers: _____	
Describe any difficulties accessing health services such as transportation difficulties, mental health symptom interference, difficulty communicating with health care providers or any other factors that may be interfering with your health care: _____			
Hospitalizations in the last two years: _____		Emergency room visits in the last two years: _____	
Can Coplat obtain this information on your behalf to improve your continuity of care? <input type="checkbox"/>			
When is your next medical appointment: _____			
<b>Housing</b>			
Stable Housing: Yes <input type="checkbox"/> No <input type="checkbox"/>		If no, please describe the nature of your housing situation: _____	
If homeless, please describe where you are currently living (shelter, family, friends, sleeping outdoors etc.): _____			
<b>Behavioral Health</b>			
Please indicate current diagnosis, nature of current services. Describe any difficulties accessing mental health services such as mental health / physical health interference, difficulty communicating with mental health care providers or any other factors that may be interfering with your mental health care: _____			
Are you currently experiencing severe symptoms such as serious depression, visual or auditory hallucinations, thoughts of suicide or self-harm? If yes, please describe: _____			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please describe the action taken to secure the person's safety: _____		Outcomes: _____	
Current Providers: _____		Are you currently on a wait list for services? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Agency or organization: _____	
Current Mental Health Providers: _____ Address: _____ Phone number: _____			
Have you sought emergency services treatment at either Monadnock Family Services, Chester Medical Center, or another organization in the last twelve months? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Diagnosis: _____			
Have you received inpatient mental health services in the last two years? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, Can Coplat obtain this information on your behalf to improve your continuity of care? <input type="checkbox"/>			
<b>Activities of daily Living: Do you have difficulty with hygiene, self-care, managing life tasks such as cooking</b>			

cleaning, paying bills etc. If yes, please describe: _____	
_____	_____
<b>Substance Use / Misuse Information</b>	
_____	
Chemical Dependence/Substance Abuse/Use Yes / No _____	
Please describe history of abuse / misuse, current use, and longest period of abstinence: _____	
Are you currently in treatment? Yes/No _____	If yes, please describe the nature of services: _____
Current Providers: _____	Would you like assistance obtaining substance abuse services? _____
Are you on a wait list for substance abuse services? Yes/No _____	Are you on a wait list for substance abuse services? Yes/No _____
Do you feel that substance abuse interferes with your ability to function? YES/NO: If yes, please describe the nature of difficulty: _____	_____
Do you feel you are at risk of severe or other serious consequences due to current use? _____	If yes, if not steps what steps will be taken to address substance abuse risk? _____
<b>Intake and Triage Summary</b>	
Based on this assessment, please describe what steps will be taken to engage the referred individual in services: _____	
Coplat Staff: _____	
Date: _____	

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

The second team transition was the departure of one of the care coordinators employed at Monadnock Collaborative in early September, 2018. Given the decrease in new referrals and limited project onboarding at that time the team decided to hold on rehiring until other features of the project had stabilized. After reworking some of the referral tracking, data entry for the intake form this process was well on its way. In parallel the team reviewed their primary mission and re-clarified some of the eligibility parameters for joining the program. This process allowed the new blend of staff at both sites to come back to a shared perspective on enrollment. Through this the team generated a new one page information sheet for service providers and are working on expanding information available to their client population.

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

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

Some primary objectives during this period of work have been:

- Updates to the clinical referral processes for new client eligibility and program onboarding
- Capture of data on Co-Pilot participants by quarter and referral tracking. See Below:

<b>Copilot Participants</b>		
<b>Year 2</b>	<b>Q1: 7/1-9/30/18</b>	<b>Q2: 10/1-12/31/18</b>
Active Participants	27	30
Pre CTI		1
Participants CTI Phase I	0	2
Participants CTI Phase II	7	0
Participants CTI Phase III	5	8 (4 of these ended CTI phase 3 in December)

Participants ECC	15	19
# of Completed Participants to Date	11	15
Total Number of Referrals from CMC-DHK		12 (7 CTI, 5 ECC)
Total Declined by Team		6 (Primarily due to Insurance elig.)
Total Assigned but not engaging after 30 days		

- PDSA for Patient Screening and Data Collection
  - Revisit identified screening tools
  - Use comparative process to narrow down screening tools to 3 or fewer choices
- Creation of patient survey document. See below for a sample of the survey questions:

**Copilot Basic Data Collection Survey**

**COPILOT PARTICIPANT SURVEY**

Dear Copilot Participant,

To provide you with the best services possible we appreciate your willingness in taking this survey. This information will help us identify program strengths and area of improvement in order to provide you with the best services possible.

Thank you for participating in this survey!

Sincerely, your Copilot team.

1. Overall, I am satisfied with the Copilot program.

Strongly agree       Disagree  
 Agree       Strongly disagree  
 Neither agree nor disagree

Comment:

2. My Copilot staff person helps me review my needs. (Examples: housing, Dr. appointments, transportation, services).

Strongly agree       Disagree  
 Agree       Strongly disagree  
 Neither agree nor disagree

Comment:

3. I am actively involved with my plan of care and service goals. (I make choices about and agree to the services that I am receiving).

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

Comment:

4. My service needs are carried out in a timely manner. (Example: Copilot staff help me to get what I need like housing, appointments, and transportation).

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

Comment:

5. I am treated with dignity and respect by the Copilot staff.

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

Comment:

6. I feel listened to and understood by the Copilot staff.

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

Comment:

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

- Strongly agree                       Disagree  
 Agree                                       Strongly disagree  
 Neither agree nor disagree

Comment:

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

- Strongly agree                       Disagree  
 Agree                                       Strongly disagree  
 Neither agree nor disagree

Comment:

9. What is your first name?

10. What is your date of birth?

Date / Time

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

- increased  
 decreased  
 stayed about the same

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

0  60

3

The following guidance is shared when administering the survey to participants:

**“Survey implementation administration guidance:**

1. Introduce self as representative of the Copilot project.
2. Identify that project is implementing survey for 2 purposes: One to evaluate work of the Copilot team, and, Two to collect information that can inform benefits of Copilot to participants. And that their answers will be anonymous unless they choose to have their name documented at the end of the survey.
3. Ask the client if they could help us by answering the survey questions over the phone. If yes....

Let them know that as the survey administrator I will document their answers including any specific comments and that I will repeat what I have documented to make sure it is the answer they want me to record.

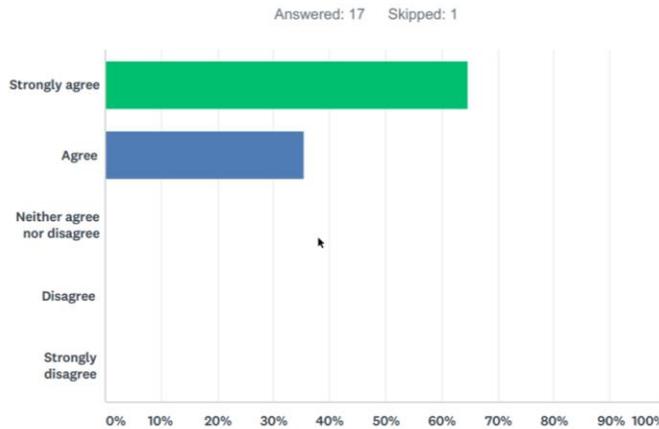
**Additionally:**

- As survey administrator, if client expresses concerns about staff or project, let them know that I can share the concerns with team and ask that the care coordinator follow up with them based on what they have shared; **OR** let them know that they can contact Glenn as the project lead or that I can ask Glenn to call them.
- As administrator Jen will be friendly and engaging but will redirect client to their care coordinator if they want to talk about their needs or plan of care.”

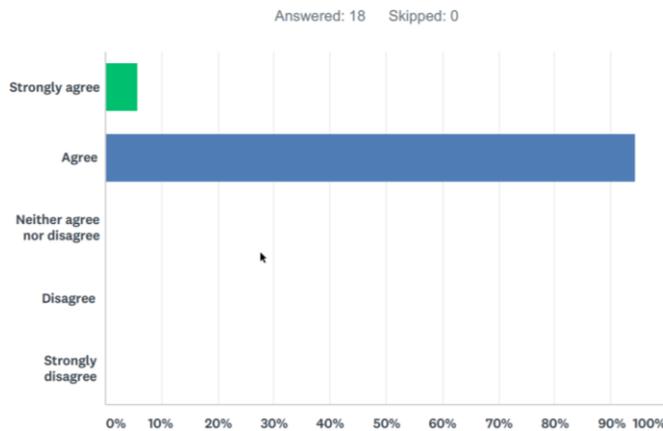
Data tracking processes refined and collection of outcome data capture quarterly

- This has been supported by the collection from the new intake tool and the generated quality outcomes from the survey. See below for examples:

Q2 My Copilot staff person helps me review my needs. (Examples: housing, Dr. appointments, transportation, services).



Q8 I am better able to take care of my daily needs since being in the Copilot program. (Examples, bathing, taking medication, eating, going to appointments).

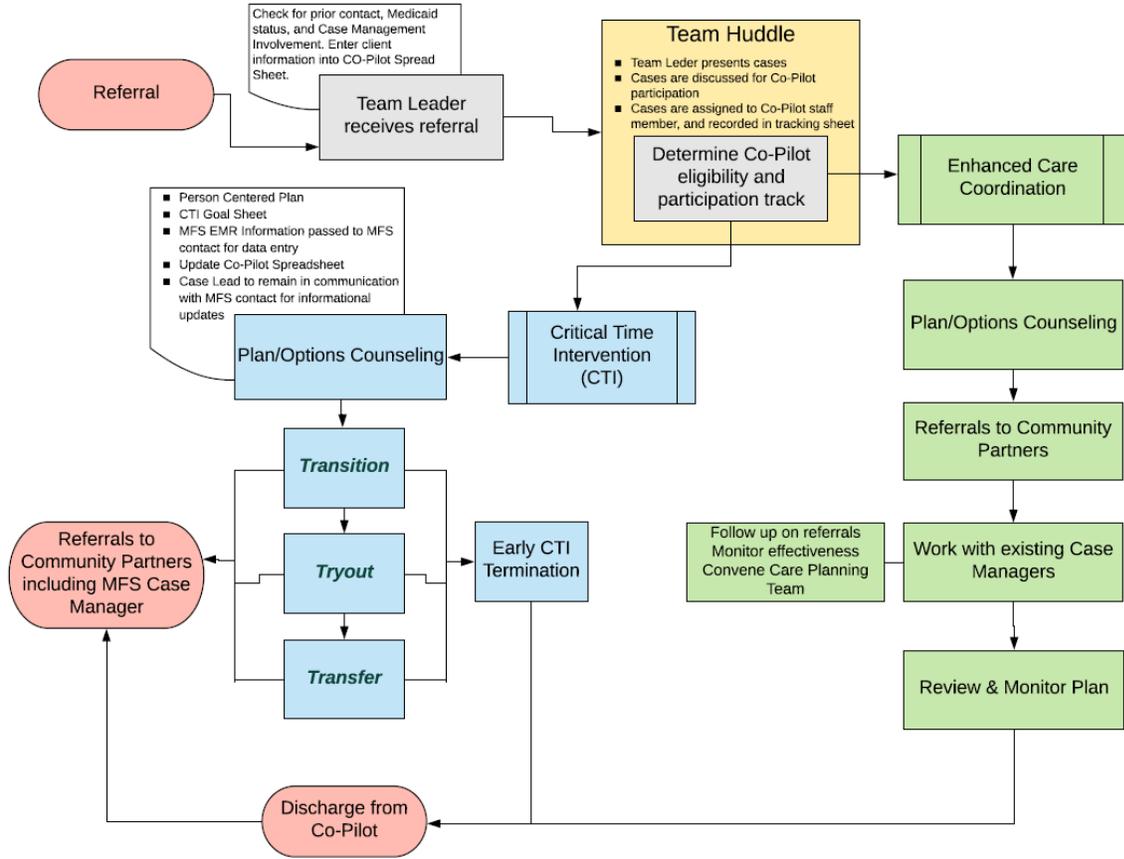


Please see below for the project materials created by the team in the January- June, 2018 semi-annual period: ([Unchanged for July-December, 2018](#))

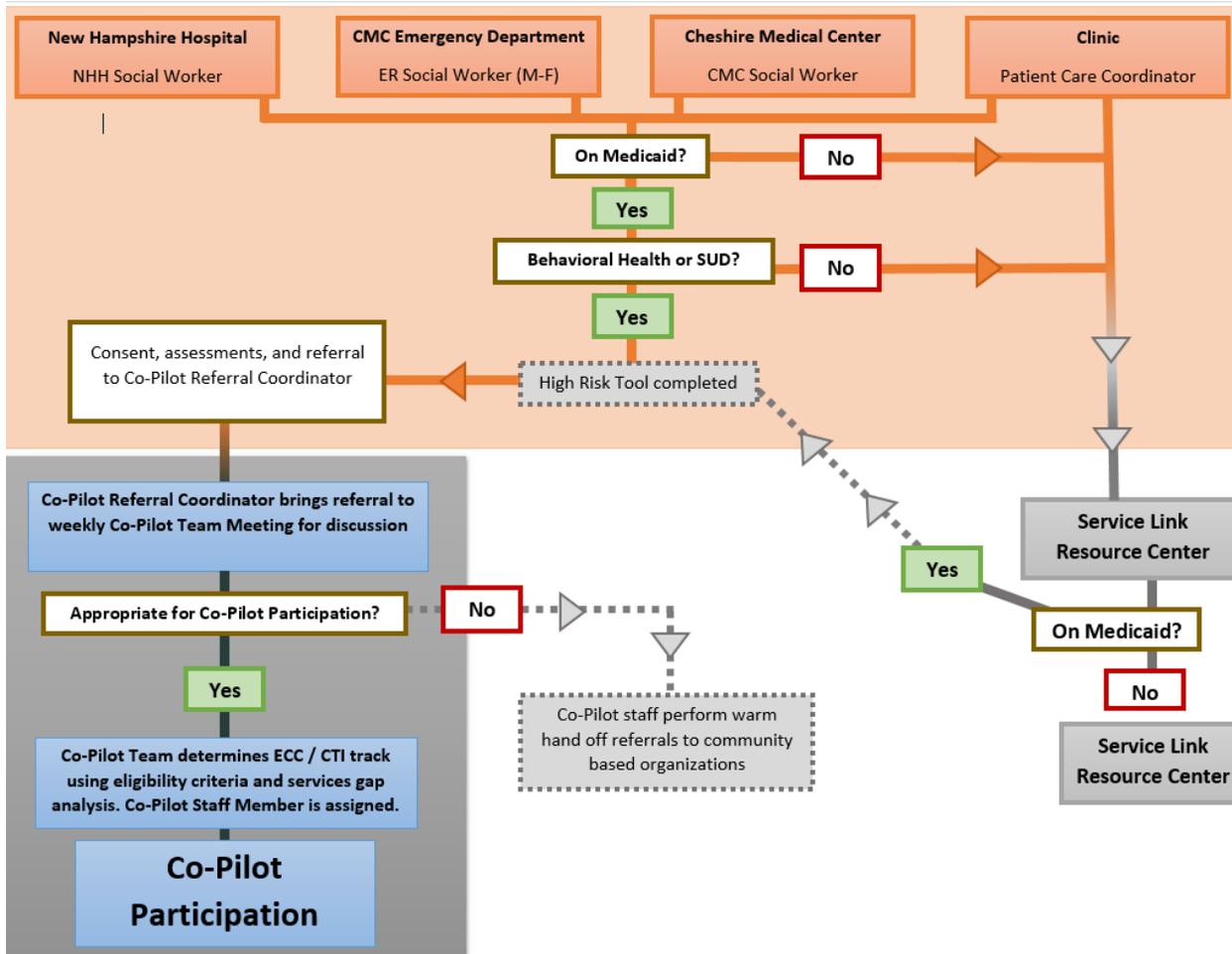
- The team will be working on updating all program documentation to reflect the new operational processes in the January-June, 2019 term.

High Level ECC/CTI Process Map and Program Narrative

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



Updated Referral Flow Chart



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

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

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

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

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

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

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

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

Performance Measure Name	Target	Progress Toward Target			
		As of 12/31/17	As of 6/30/18	As of 12/31/18	
<b>Project Defined Patient Measures</b>					
<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>	<b>Will become effective post Q1, Q2 of Project Implementation due to program launch, training</b>		<b>Performance measure will begin tracking in next quarter</b>		
Indicator 1: Decrease in client self-reported poor mental health days				N/A	<b>13/30 Responded</b> 11 of 13 reported a Decrease
Indicator 2: Increase in number of social interactions per week				N/A	8 of 13 reported an Increase
Indicator 3: Increase in participation in any groups (social, religious, self-help, public service, etc.)				N/A	<b>19/30 Responded</b> 14 of 19 replied Do not agree/disagree
<i>Reduce overall homelessness in Cheshire county from 96 in 2016 to 86 (source: NHDHHS-County Level Information)</i>					
Indicator 1: Increase in number of people placed in housing				5 out of 14	5 of 14 respondents homeless at time of referral- 3 additional have been housed
Indicator 2: Increase in number of people working with housing services				12 out of 14	Increase of 5
Indicator 3: Decrease in consecutive days without shelter				N/A	No reported decrease
<i>Reduce social isolation (source: GMPHN Community Survey)</i>					

Indicator 1: Increase the number of social engagements (i.e. church events, visits with neighbors/friends, attending community events)			Team reported 294 social interactions across 40 clients	18 reported agree or no change
Indicator 2: Increase the number of referrals accepted for services and social resources in the community			Team reported 36 closed loop referrals to other programs or services outside of MFS	This measure has become difficult for the team to track and is revamping their collection processes
Indicator 3: Increase the number of individuals identified as members of their support network			N/A	The team has agreed that this Indicator is too subjective and there is not consistent ability to answer. The group will be reviewing and revising or eliminating this indicator
<b>STC Defined Program Measures</b>				
<i>All performance measures identified within the evaluation plan milestones</i>	100%	100%	75%	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				100%
D. Use of assessment, treatment, management and referral protocols	100%	100%	100%	
<i>Initiation of Data Reporting</i>				
A. Number of individuals served vs. projected			N/A	58 /86
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected			100%	100%
C. Impact measures as defined in evaluation plan, including annual	100%	100%	100%	100%

evaluation of fidelity to evidence-supported program elements				
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The team continues to be working with Cheshire Medical Center so that the project can extract data from their more advanced systems on emergency room usage, improved health measures and similar reporting fields. Progress on the development of these mechanisms will be reflected in subsequent monthly, quarterly and semi-annual reports.

### C-3. IDN Community Project: Workforce Staffing

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Care Transition Coordinators	2 FTE	0	2 FTE	2 FTE	1 FTE, 1 Recruit to Hire <b>MET</b>
Enhanced Care Coordinators	2 FTE	0	2 FTE	2 FTE	2 FTE <b>MET</b>
Supervisor	.1 FTE	0	.1 FTE	.1 FTE	.1 FTE <b>MET</b>

- During CY2018 the Copilot team has experienced a high rate of turnover. The team did not formally project turnover rates for the project but has consistently over the CY dealt with staff transitions almost quarterly. As reference in the narrative section above this has caused downstream impact on referral timeframes and new client intakes. The team with support of IDN1 is working on staff satisfaction and team development.
- **As of early January, 2019 the recruit to hire processes had concluded and the team is fully staffed with 4.1 FTE.**

## C-4. IDN Community Project: Budget

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

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

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

**REDACTED TABLE**

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

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

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

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

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project. NOTE: Project C1: Care Transitions does not require the use of standardized assessment tools. If the IDN chooses to use any standardized assessment tools, please list them.

The team has experienced challenges in the CCSA (CANS/ANSA) deployment across the Co-Pilot project as similar assessment is not conducted at M.C. The team anticipates with the fall, 2018 onboarding of the B1 project at CMC/MFS standardized screening in the region will streamline the processes around some of the Co-Pilot patients. More details on this rollout are anticipated in early fall, 2018.

Standard Assessment Tool Name	Brief Description
CANS/ANSA (CMHC Mandated Screener)	Childs Needs and Strengths Assessment/ Adult Needs and Strengths Assessment
CTI Tracking Tool	CACTI Developed Patient Reporting Tool
Intake and Triage Form , Survey Tool	Team Developed- Based off of evidence based tools
Framed by CTI Model, Person Centered Planning	

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

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

**Updates as of December 31, 2018:**

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

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

Additionally, the Community of Practice sessions supported by CACTI have facilitated an open discussion across all of the IDN’s implementing the C1 project as to which tools are in use and how they are being used in each Region. These conversations are ongoing and the IDN1 team anticipates that, as tools are reviewed statewide, the group streamline the assessments and protocols leveraging the best practices available. Despite variance in the populations being targeted for C1 implementation across regions, the IDN1 team feels there is sufficient synergy to make shared toolkits a positive resource for all.

Protocol Name	Brief Description	Use (Current/Under development)
Family Caregiver Assessment	Support and assistance questions, safety, & ADLs	Service Link
Person Centered (PC) Counseling check sheet	Outline of key criteria that show fidelity to a PC approach	Used by all Project Coordinators

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

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

Project Team Member	Roles and Responsibilities
[REDACTED]	CEO at MFS: Serving as the lead fiscal agency for the C1 Proposal, Additional 40 hrs. per year contribution
[REDACTED]	CEO at Monadnock Collaborative: Serving as the housing agency for CTC Positions, Additional 40 hrs. per year contribution
[REDACTED]	Program Director at Monadnock Collaborative: Supportive role for CT Coordinator Positions, Additional 40 hrs. per year contribution
[REDACTED]	Director of Primary Care at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
[REDACTED]	Nursing at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
[REDACTED]	Director of Operations at Cheshire Medical Center: Serving as a CMC liaison, Additional 40 hrs. per year contribution
[REDACTED]	Clinical Supervisor at MFS CTI Coordinators ( 1 Currently in Recruit to Hire) ECC Coordinators

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

All Co-pilot staff are trained in person-centered planning, motivational interviewing and case management best practices. The team has created an outline training tool see below:

**Key to Trainings**

<p><b>IT/IS</b></p> <ul style="list-style-type: none"> <li>• Refer</li> <li>• MFS EMR</li> <li>• KNO2</li> <li>• CMC-DHK EMR</li> </ul> <p><b>MFS Specific</b></p> <ul style="list-style-type: none"> <li>• ANSA Certification = ANSA</li> <li>• MFS Orientation = MO</li> <li>• Intake/Triage Assessment = Triage</li> </ul> <p><b>CTI Model</b></p> <ul style="list-style-type: none"> <li>• CTI (initial and ongoing community of practice) = CTI</li> <li>• CTI trainer = CTI+</li> </ul> <p><b>ADRC/NWD Specific</b></p> <ul style="list-style-type: none"> <li>• Person Centered Options Counseling Certification = PCOC</li> <li>• AIRS Certification = AIRS</li> <li>• SLRC Orientation = SO</li> </ul> <p><b>CMC-DHK</b></p> <ul style="list-style-type: none"> <li>• HR and Onsite Orientation = CMCO</li> </ul> <p><b>Copilot Specific</b></p> <ul style="list-style-type: none"> <li>• Referral and Intake Process – CP1</li> <li>• Copilot Workflow = CP2</li> <li>• Assessment and Follow up Assessments = CP3</li> <li>• Tracking and Reporting = CP4</li> </ul>
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**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				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
C-5	IDN Community Project Key Organizational and Provider Participants	Table				
C-6	Clinical Infrastructure: IDN Community Project Standard Assessment Tools	Table				
C-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
C-8	Clinical Infrastructure: IDN Community Project Roles and Responsibilities	Table				
C-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

## Projects D: Capacity Building Focused

### IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

*See Appendix D-1 for Excel Workplan of D3 Activities*

*IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.*

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

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

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

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

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

#### Overview of the PATP-IOP Project Architecture: As reported in July, 2017 SAR

The PATP- IOP project pilot will build off of the existing structure of the Perinatal Addiction Treatment Program to develop and pilot an evidence-based, gender-specific, trauma-informed intensive outpatient treatment program to meet the critical treatment needs of pregnant and parenting women with substance use disorders (SUD) in the DSRIP Region 1 catchment area. The project will serve Medicaid-eligible women with substance use disorders who meet criteria for ASAM level 2.7 services, with a particular emphasis on the needs of women who are pregnant or parenting young children. The primary project objectives are as follows:

- Implement and evaluate an evidence-based, trauma-focused curriculum to meet the special needs of women qualifying for ASAM level 2.7 (Intensive Outpatient) services, including medication assisted treatment
- Address the comprehensive medical and psychiatric needs of participants through provision of co-located psychiatric and reproductive health services with linkages to primary and specialty medical care

- Develop protocols for comprehensive screening and service coordination to address social determinants of health which present particular barriers to treatment and recovery for women
- Provide on-site childcare to facilitate access to and engagement with treatment for women with young children
- Clearly define and develop the business case for a scalable, integrated intensive outpatient model of care for the target population
- Help women to consolidate their recovery as an investment in their own lives and their children's future

Currently the only gender-specific SUD treatment option in Region 1 is that provided by the Dartmouth-Hitchcock Perinatal Addiction Treatment Program (PATP) in Lebanon, a once weekly office-based outpatient program. The proposed project builds on the existing infrastructure of the current program, which includes deep knowledge of the social and health needs of this population, medication assisted treatment, weekly group therapy, peer support, integrated psychiatric and reproductive health care, and case management for pregnant and parenting women.

The PATP currently sees upwards of 40 woman during their two session clinical Wednesday. The IOP will target women from this pre-existing patient pool who need higher intensity services and from there will expand the number of individuals served. The proposed program will provide a replicable model for increasing access to intensive substance use treatment services for a population with significant vulnerability and barriers to care. Specifically, we anticipate that:

- 25-50 women of reproductive age will be provided with comprehensive, intensive addiction treatment annually that they would not be able to access otherwise
- 25-50 women with difficult to treat co-occurring disorders will be provided access to psychiatric care and will have the opportunity to stabilize their mental health disorders

25-50 women and their children will be able to access resources needed to avoid homelessness, food insecurity, sexual exploitation and exposure to domestic violence.

### Current State Updates from July- December 31, 2018:

During the semi-annual period the PATP-IOP Expansion project team met 2x monthly in person to work on project expansion and the protocols to support programmatic infrastructure change within the project. During this semi-annual period the PATP was fully staffed and pursuing ongoing team training. The IOP has been continuously seeing patients and expanding throughout the July-December term.

- 1) Continued expansion of referral sources for the PATP/IOP
- 2) Continued enrollment of participants in the IOP
- 3) Readjusted services to expand to Fridays
- 4) Alignment with SUD Hub work and expanding capacity to support
- 5) Childcare, recovery coaching and case management inclusion in the IOP schedule
- 6) 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.

- 7) Focus on continuing to engage community partners in PATP program and to facilitate connections between PATP and community agencies
- 8) Staff receiving Circle of Security training.
- 9) Will be incorporating 1 to 2 guests per week to support program development
- 10) Offering wellness activities for patients and seeking to set up recurring/sustainable option for yoga offered with the program
- 11) Seeking opportunities to include blood draws on site and/or to have nursing support for the mid-wife appts.
- 12) The team is targeting including a more intensive SDoH screen for their population. Currently reviewing the PRAPARE tool.
- 13) Continue to enrich program curriculum and refine program structure
- 14) Collect and interpret data regarding outcomes

Much of the work completed by the project team throughout January-June, 2018 was focused on mapping their expansion of the IOP participants, PDSA of the present processes, and refining data collection. Some completed work from July-December 31, 2018:

Updated Patient Handbook; (*Minimal Changes from January-June, 2019 Submission*)

Orientation Handbook Guidebook:

## 1. Welcome

Welcome to the **Moms in Recovery** Program. This booklet is designed to help orient you to the program. The Moms in Recovery Program is a health care program for women who are pregnant or parenting and also have a substance use disorder. At the Moms in Recovery program women can get buprenorphine treatment for opioid use disorder. They can also receive prenatal and postpartum care, well woman checkups and family planning counseling, parenting classes, case management support (such as support for finding better housing, finding transportation options, or signing up for benefits) and mental health care. Every woman in the Moms in Recovery also participates in group therapy for addiction treatment and has access to individual therapy to support her recovery.

## 2. Our Mission

- To provide access to addiction treatment for pregnant and parenting women who need support to manage a substance use disorder.
- To address holistically the physical, emotional, social and spiritual needs of our patients.
- To increase the number of pregnant and parenting women who remain successfully engaged in the recovery process.
- To improve collaboration between community agencies serving pregnant and parenting women with substance use disorders and strengthen the social safety net for families who are impacted by addiction.
- To assist our patients in developing the skills and supports they need in order to care for their children and build lives that are safe, fulfilling, and free from substance misuse.

### 3. Staff

[REDACTED]

### 3. Team Approach to Treatment

At Moms in Recovery, we work as a team to provide high quality addiction treatment to our program participants. Your treatment team includes a midwife, psychiatrists, therapists, a recovery coach, and a resource coordinator. We all work together to provide you with the best care that we can. Decisions about treatment and decisions about the program are never made by just one person. Important treatment decisions, such as making referrals to a higher level of care, are always made in collaboration with you and the entire treatment team. The Moms in Recovery treatment team meets every week to make sure everyone is updated on every patient's progress.

### 4. What to Expect from Treatment

Although buprenorphine treatment (Suboxone) for opioid use disorder is one of the services you may receive here, it is only one part of the program. You will also receive prenatal and postpartum care during pregnancy, well woman check-ups and family planning counseling, parenting classes, case management support (such as support for finding better housing, finding transportation options, or signing up for benefits) and mental health care. You will participate in group therapy for addiction treatment and individual therapy to support your recovery. You will get to know other women who have been in similar situations and understand what you are going through. You will be listened to carefully and you will not be judged!

We ask you to set aside at least three hours to attend the weekly Moms in Recovery outpatient program. Please come at least half an hour before group starts so that you have time to get tested and take care of

other business. The doctors and midwife see women on a first come-first served basis, so the earlier you arrive on your clinic day, the sooner you will be seen. Sometimes you may have to wait to visit with the doctor, the midwife, the resource coordinator or with your individual therapist. Thank you for your patience. We do our best to make sure you are seen as quickly as possible.

## **5. Your Rights**

As a client of Moms in Recovery, you have several rights. The following is a list of rights you have as a client of the program.

You have the right to:

- Decide not to enter any level of treatment services that is provided at Moms in Recovery.
- Decide to terminate services at any time.
- A safe environment, free from emotional, physical, and sexual abuse.
- Be treated with respect by self, staff, and other clients.
- Be free from discrimination from self, staff, and other clients, including but not limited to racial, color, sexual orientation, national origin, disability, religious, age, gender, or economic discrimination.
- Complete and accurate information about your treatment including goals, methods, potential risks and benefits, and progress.
- Information about the professional capabilities and limitations of any professional involved in your treatment.
- Receive treatment from trained and qualified professionals.
- Be informed about the limits of confidentiality, the situations in which your counselor and/or the agency is legally bound to disclose information to outside persons or agencies, and the types of information that will be disclosed.
- Request the release of your clinical information to any agency or person that you choose.
- Be referred to appropriate community services, based on individual needs, as we are able to identify them.
- If you are asked to leave the program, to know why you are being asked to leave and what conditions you must meet in order to return.
- If you are unhappy with your care, you have the right to express this with your doctor, nurse or Dartmouth-Hitchcock Patient and Family Relations at (603-650-4429)

## **6. Confidentiality and Access to Treatment Records**

The confidentiality of program participant records maintained by Moms in Recovery is protected by federal law and regulations. Generally, we may not say to a person outside of this hospital that a participant receives services here, or disclose any information identifying a participant as a person with a history of misusing alcohol or other drugs. The exceptions to this include (a) with written consent from you, (b) if the disclosure is permitted by court order, (c) the disclosure is made to medical personnel in a medical emergency, or (d) to report suspected child abuse and neglect or suspected elder or incapacitated adult abuse, neglect, or exploitation.

Violation of the federal law and regulations by this program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and regulations do not protect any information about a crime committed by a client either on Dartmouth Hitchcock Medical Center property, against any person who works for DHMC, or any threat to commit such a crime. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 CFR part 2 for federal regulations)

Unlike individual treatment, confidentiality of group therapy is not protected by law. Group members must be able to maintain the confidentiality of other group members in order to participate in treatment here. Violating other members' confidentiality may cause you to be discharged from this program. Program participants with concerns about confidentiality should discuss them with a staff member.

Moms in Recovery participants may access portions of their own treatment records through the Dartmouth-Hitchcock patient portal "myD-H": <https://www.mydh.org/portal/>

## 7. Your Responsibilities

- Attend on time to avoid disrupting group. Participants who arrive more than 10 minutes late may not be able to attend group.
- Call in advance if you need to miss an appointment; you may be required to attend a make-up group or come to the clinic to provide a UDS in order to obtain your prescription. Repeated missed appointments may result in discharge from the program.
- Make a commitment to attend recommended prenatal, postpartum, and women's wellness visits at the program
- Do not share information about medication doses or formulations with others in group.
- Provide truthful and complete information to your treatment providers. This enables you to receive the best possible care.
- If relapse occurs, you may be referred to a higher level of care. Failure to accept this referral and/ or continued drug use may lead to discharge from the clinic.
- You are responsible for maintaining insurance or completing paperwork for financial assistance if you cannot afford the fees associated with care.
- All participants will respect the privacy of other participants in the program and will keep any information about them, including the fact that they attend this program, confidential. This means that you agree not to share anything you have heard about another person in the program or anyone you have seen while attending the program to friends, family members or acquaintances. Information about other people's treatment, including the fact that they attend this program, on social media must never be shared. Violation of this guideline will result in a warning, and any subsequent violation will result in dismissal.
- We need to be able to contact you. You must provide program staff with a current address and current phone number as well as an alternate phone number of someone who can reach you. You are solely responsible for keeping this information current and for keeping voicemail boxes open to receive new messages.
- Smoking is prohibited near the doors of the Addiction Treatment Program.

## 8. Components of Treatment

- Group addiction treatment with other pregnant women and mothers
- Individual counseling for addiction and mental health needs
- Medication assisted treatment (including buprenorphine) for substance use disorders
- Prenatal, postpartum, and well-woman care offered on site
- Pediatric care offered on site
- Recovery coaching
- Help accessing resources such as housing, transportation assistance, fuel assistance, child care, etc.
- Food shelf and healthy snacks offered on site

- Diaper bank
- Donated maternity and infant items

## 9. Prenatal Visits/Women’s Wellness

Your physical health is an important part of your recovery! We are committed to helping you to be as healthy as possible. We offer prenatal and postpartum visits, women’s health care, immunizations; testing for sexually transmitted infections, HIV, and Hepatitis; and help getting established with a primary care provider.

## 10. Pediatric Care

As part of our program, you have access to on-site, recovery friendly pediatric care. This includes well child care, immunizations, sick visits, developmental checks, and Reach out and Read books. You will also have the choice to join our pediatric medical home, including 24/7 phone access and full service clinics at DHMC and Heater Road. We understand that having an infant at home can be both wonderful and stressful, so we would like to make care of your children part of your successful recovery.

## 11. Group Schedule (subject to change)

[REDACTED]

[REDACTED]

## 12. Group Guidelines

### Attendance

Consistent attendance at your assigned group is important both to your recovery and to prevention of relapse. Missing groups may jeopardize your treatment. Please call us ahead of time and let us know if you have a conflict.

### Lateness Policy

You are expected to arrive at least 30 minutes before group begins in order to complete urine drug screens and take care of other business.

You are expected to be seated in the group room and be ready to start group before the scheduled start time. For example, if your group starts at 10am you are expected to arrive no later than 9:30. Anyone who is more than 10 minutes late (i.e. entering the group room later than 10:10) cannot attend group.

If you have a transportation problem that will cause you to be late, please call and let us know. If you usually attend the 10:00 am group, you may be able to attend the 12:30 group.

Participants who arrive late may be asked to attend another meeting at Rivermill as a ‘make up session’ and may be given a prescription that only lasts until this ‘make up session.’ After you have attended the make-up session you will be given the rest of your usual prescription.

Remember, punctuality is a way to be respectful of your own and other people's time boundaries.

### **Attitude**

Members can show respect for each other by listening fully when others are speaking. Members can show respect for each other by silencing or shutting off their cell phones during groups. The group time is everyone's time. Please don't dominate the discussion. Listen 10 times as much as you speak. Practice staying out of judgement mind by working on listening skills, refraining from giving advice, learning to be comfortable with silence, using "I-statements" and reaching out with validating comments and empathy.

The Moms in Recovery Program believes it is important you are open and honest with your treatment providers and peers at all times. Openness and honesty during group can contribute positively toward your recovery goals.

### **Confidentiality**

What is said in group stays in the group. Names of people in group stay in group. If chance brings you or another group member into contact outside of group it is best not to acknowledge each other until you've had a chance to speak about it in the next group session and have mutually agreed on whether conversation is acceptable. Never mention anything that happens in group on social media, such as Facebook or Twitter. Members with concerns about confidentiality are encouraged to speak with a clinician.

### **13. Playtime and Children in Groups**

"Playtime" is our family support program for moms who need to bring their children to group therapy sessions. "Playtime" is a child friendly space where your child can play with specially trained, carefully selected hospital volunteers. The volunteers will hold your babies and play with your toddlers. For insurance reasons, the volunteers cannot feed your children, change diapers or help with toileting. If your child needs you, the volunteers will let you know and you will be excused from group to take care of your child.

There is room for up to four children or babies in the Playtime Space. Because space is limited, if you have another childcare option we ask you to please take advantage of it. We want every mom to have a safe space to leave her children while she attends treatment, and Playtime is a safe, comfortable place for your children. If you know you need to use the Playtime program, please sign up with our receptionist so that you can be sure there is a space available.

Moms are welcome to bring their new babies to group. Group is a place where women need a chance to focus on themselves for a few hours. If your baby is very fussy or noisy, please be respectful of other group members and take your baby out of group until she is calm.

Once your baby is older and crawling around, group is not the best place for her. Please use the Playtime program or find an appropriate caregiver for your child so you have a chance to concentrate in group.

Children who are older than four cannot come to group—it's not an appropriate place for them due to the topics that may be discussed. If you need to bring your older child with you when you attend group, and if there is space in the program, the Playtime volunteers can help supervise your child while you attend group.

Children who are younger than twelve cannot be left alone in the waiting room while you are in group. This is a liability issue for our program. If you are having trouble finding appropriate care for your older child, please talk to our resource specialist who may be able to help.

#### **14. The Parent Education Program**

We offer a parent education group about four times a month using a curriculum called Circle of Security. Women who struggle with substance use disorders, and women who grew up in families where addiction was a problem, often have guilt and anxiety that interferes with their ability to relax and enjoy time with their children. These feelings can interfere with the ability to set healthy limits with your children and manage their intense feelings. Circle of Security is a program that helps parents develop a secure, healthy attachment with their children. The program lasts for eight weeks. If you have completed the IOP or nine months of treatment with the Moms in Recovery program and you are in a stable place in your recovery, you are welcome to join the Parenting Group. The Parenting Group counts as your weekly group therapy. After you have completed the Parenting Group you can request to join the maintenance group and attend group less frequently.

#### **15. Pathway through Treatment**

Most women enter our program while they are pregnant. If you are pregnant you will attend the Pregnancy Group every week until after your baby is born. Once your baby is between six and twelve weeks old, you will join the Postpartum Group instead.

Some women come into treatment after their babies are born. If your baby has already been born, you will begin treatment in the Postpartum Group.

Some women enter treatment through the Intensive Outpatient Program (the IOP). If you are pregnant when you begin the IOP, you may continue with the Pregnancy Group after you complete the IOP. If you are not pregnant, you will join the Postpartum Group after you complete the IOP.

Every woman coming into the program can expect to attend group on a weekly basis for between 40 and 60 weeks—how long you continue weekly groups depends on your progress in treatment, how stable you are in your recovery and what kind of support works for you. After you have been in the program for at least nine months, and once you have completed the Parenting Education Program, you can request to go onto a maintenance schedule. Women who have switched to a maintenance schedule attend group either every two weeks or every four weeks.

#### **16. The Intensive Outpatient Program**

The Moms in Recovery Intensive Outpatient Program (IOP) will begin in February 2018. Any pregnant or parenting woman who meets criteria for an IOP level of care can join the IOP. Women in the Moms in Recovery program who are struggling with relapse may be asked to complete the IOP in order to maintain their health. The IOP schedule is:

[REDACTED]

[REDACTED]

[REDACTED]

Playtime will be available for any woman who needs to bring her child to the IOP.

## 17. Urine Drug Testing

- All program participants will provide a point-of-care urine sample for a toxicology screen for substances of abuse and buprenorphine at each visit, regardless of whether a prescription is needed that day. This urine sample will sometimes be observed by a staff member.
- Urine samples will be periodically sent out for confirmatory testing, which may include testing for alcohol metabolites, bath salts, or other illicit substances.
- It is a felony in NH to obtain a prescription using deceit, so any adulteration of urine specimens will be considered to be the commission of a crime on premises. As such, confidentiality rules such as 42 CFR Part 2 and HIPAA do not apply. We reserve the right to immediately discharge patients and notify law enforcement if urine specimens are adulterated.
- Refusing to provide a urine drug screen is considered the equivalent of a positive drug screen
- The consumption of poppy seeds in any form during your participation in our program is prohibited, as poppy seeds can confuse our urine tests and are indistinguishable from opiate use.

## 18. Coping with Relapse

We recognize that relapse is part of the disease of addiction. Not everyone in recovery from addiction will relapse, but that potential is always there. Part of the education you receive in group therapy will be about how to prevent relapse and what to do if you do have a relapse.

If you test positive for a substance you should not be using, such as opiates, alcohol or cocaine, members of your treatment team will discuss this with you individually and develop a plan to make sure you have the support you need to stop using. This may include increasing the frequency of your individual therapy sessions, going to twelve step groups and making lifestyle changes. If you test positive for an illicit substance two weeks in a row, we will refer you to a higher level of care. This could be the Intensive Outpatient Program (IOP) or it could be a residential treatment program.

### Marijuana

Many program participants are daily marijuana users when they enter our program. Some started using marijuana when they were very young. If you are a regular marijuana user, you may feel ready to stop using opiates or other “hard drugs” like cocaine, but feel that marijuana is ok for you. Some women feel that marijuana helps with nausea, or pain, or anxiety.

Moms in Recovery is an abstinence-based program. That means that we ask participants to remain abstinent from all mood-altering substances, including marijuana. There is growing scientific evidence that marijuana is not safe to use while you are pregnant or breastfeeding. We also feel that marijuana is not safe to use while you are supervising children. Finally, we believe that marijuana use is not safe for anyone who has a substance use disorder because it increases vulnerability to relapse. It is also the belief of your treatment team that marijuana use interferes with healing for people who have Post Traumatic Stress Disorder, anxiety, or depression.

We recognize that stopping marijuana use is a difficult process for some people who have been using it for a long time. While you are pregnant, we will provide you with information about marijuana use and how it can impact your baby and your recovery.

Women who are testing positive for THC are not eligible to be on a “maintenance schedule”. If you test positive for THC you will be asked to attend weekly group therapy sessions until your drug screen is negative for THC again.

## 19. Child Protection Communication

Families have both strengths and challenges and can grow and change with support and resources. Moms in Recovery staff are committed to helping you ensure the safety of yourself and family. We know you are eager to provide a safe home for your children and that the health and safety of your child is a priority. Untreated substance use disorders can affect prenatal development, parenting, and early childhood and adolescent development, but treatment can prevent these outcomes. If we have concerns about the safety of your children we will discuss these concerns directly with you. We recognize that you know your situation and family the best. Please remember that we are mandated by law to report suspected child abuse and neglect to child protection agencies. If we need to make such a report, we will communicate this directly to you whenever possible, and encourage you to partner with us in making the report. Child protection agencies work with families to help parents get the services and supports they need to keep their children at home safely and will place children in temporary out of home care only when necessary. Please speak with a clinician if you have concerns or questions about child protection involvement or communication.

## 20. Medication-assisted Treatment

- Buprenorphine is prescribed as part of an overall effort to help people become abstinent from opioids. The goal of treatment is total abstinence from all drugs of abuse, including alcohol and marijuana.
- Mixing buprenorphine or methadone with sedatives such as alcohol, benzodiazepines, or barbiturates is very dangerous due to the risk of respiratory suppression (stopping breathing). Participants who are taking benzodiazepines on entry to treatment will be assisted in tapering off these medications. Following completion of a taper, participants admitting to the use of, or testing positive for, benzodiazepines, barbiturates, or alcohol will receive one written warning and sign a contingency contract. Participants admitting the use of, or testing positive for, these substances a second time may be discharged from the clinic with a one to two-week taper of buprenorphine. Participants refusing to sign the contingency contract will be given a one to two-week taper of buprenorphine and will be discharged from the clinic
- The total dose of buprenorphine will not exceed 16 mg for any patient, other than occasionally in the third trimester of pregnancy.
- Suboxone (buprenorphine/naloxone) is safe and effective for both pregnant and non-pregnant women. Anyone who joins the program taking Subutex (buprenorphine monotherapy) during pregnancy will immediately be transitioned to Suboxone (buprenorphine/naloxone) postpartum.
- We ask all program participants to pick a “home pharmacy” and sign a release of information for that pharmacy.
- Lost or stolen prescriptions will not be replaced. Program participants who allow their medication to be stolen or lose their medication more than once will be discharged from the clinic.
- We periodically call program participants to come in for unscheduled pill/strip counts and urine drug screens. When this occurs, you have 24 hours to present to the clinic or you may be discharged from the clinic. It is your responsibility to have a working phone number, and not receiving the message will not prevent discharge.
- Women who are on methadone maintenance treatment are welcome to attend group and participate in all aspects of the program. Because Moms in Recovery does not prescribe methadone, women choosing treatment with methadone need to obtain medication from another program, usually Habit Opco in West Lebanon).
- Women choosing treatment with buprenorphine (Suboxone) for medication assisted therapy must receive their prescriptions through our program in order to participate. Patients who are

prescribed buprenorphine by other providers are not eligible to receive Moms in Recovery services.

## 21. Diversion

It is against the law to provide a controlled substance to another person to whom it is not prescribed. Program participants who divert their buprenorphine by selling or sharing it with others will be immediately discharged from the clinic with a one to two week taper of buprenorphine. The diversion does not have to be established “beyond a reasonable doubt”.

Buying, selling, or sharing illicit substances with other group members will also lead to discharge.

## 22. Making Changes in Your Life

Life changes are difficult for anyone, but especially for those living with the disease of addiction. Good, bad, or indifferent, making a change can feel overwhelming and distressing, particularly for those of us suffering from this disease. Becoming a new mother and choosing recovery at the same time might feel like it’s too big a task for anyone to accomplish. The team of experienced, understanding and non-judgmental staff at the Moms in Recovery Program are here to help you move forward in becoming both a successful parent and a person who is in recovery from addiction. There is no doubt that both come with their own sets of struggles, joys, and imperfections. But here you can gain confidence, knowledge, support, and the reassurance that you are never alone in your journey. Everyone deserves a quality of life worth living and everyone deserves a chance to be healthy

Organizations Receiving Information and Outreach:

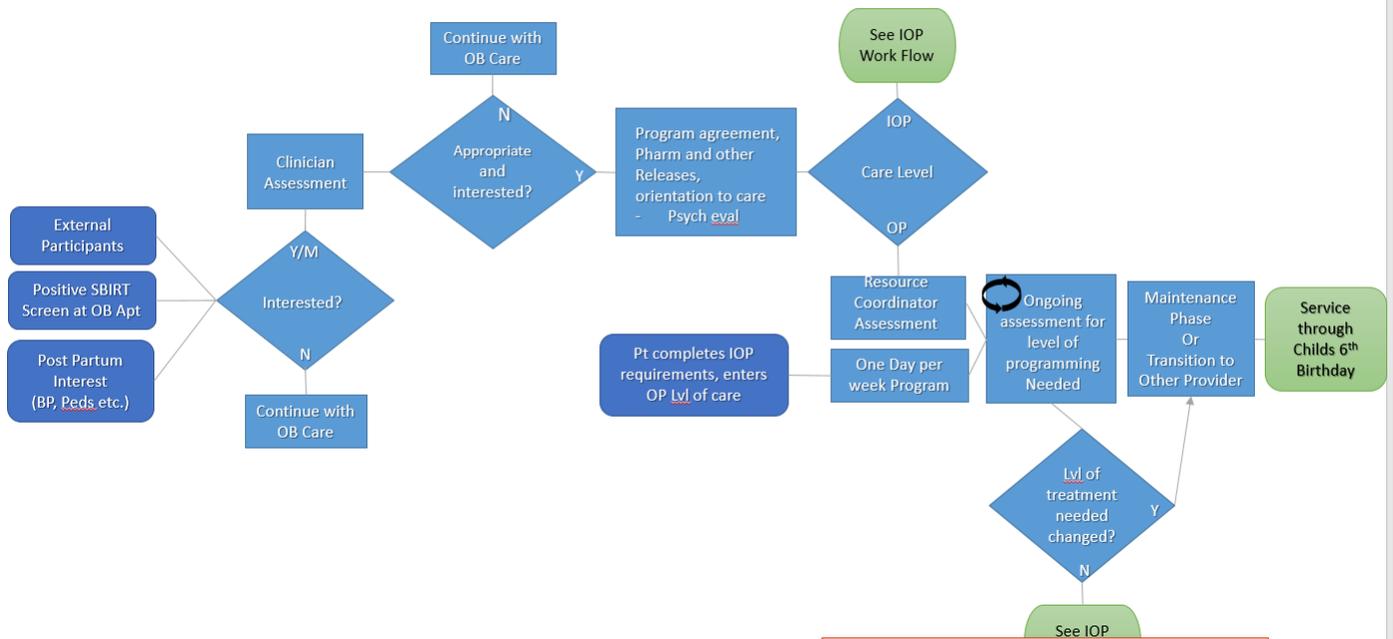
Road to a Better Life
Groups
Habit Opco
West Central Behavioral Health
Little Rivers Health Clinic
Bradford Psychiatric Associates
Road to a Better Life
Phoenix House
Wise
TRAILS Program
TLC Family Resource Center
Turning Points Network
Upper Valley Haven
Family Place Parent Child Center
Twin Pines Housing Trust
Headrest
Women's Health Resource Center
Listen Thrift Store
Child Support District Office

Updated Current Schedule:

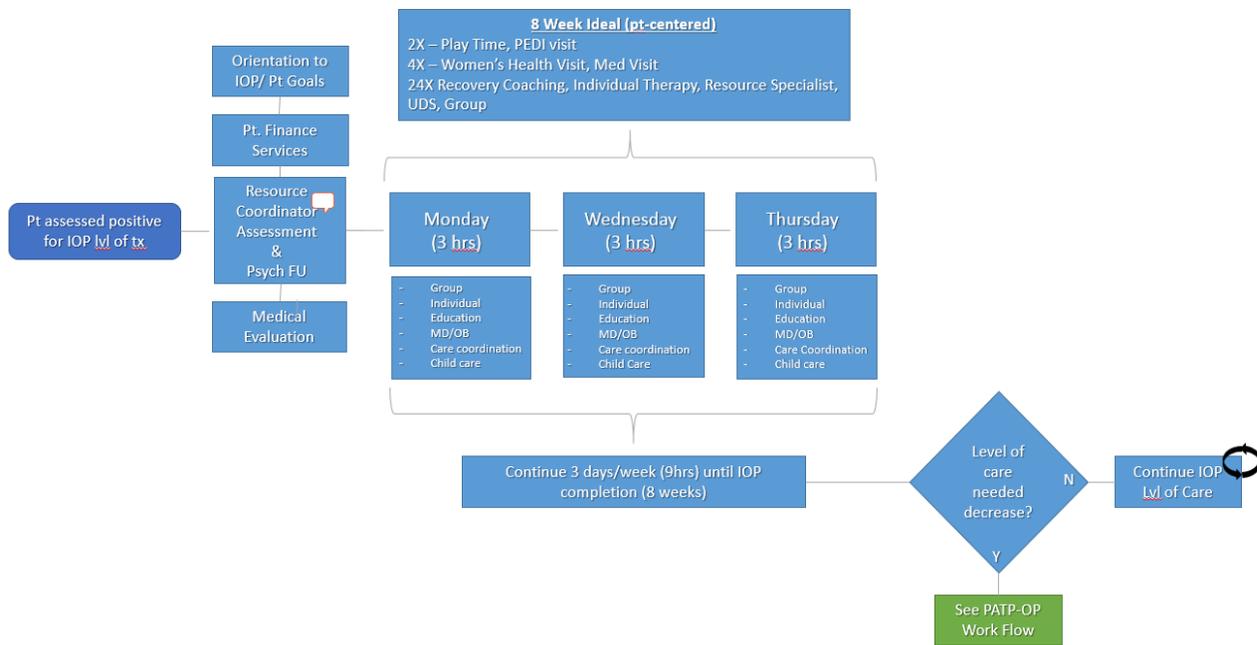
**REDACTED TABLE**

Updated Process Maps:

### DHMC: PATP-OP Future State Program Flow



### DHMC: PATP-IOP Future State Program Flow



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

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

- Number of individuals served (during reporting period and cumulative)

- All performance measures identified in the evaluation project plan.

The PATP-IOP project team during July-December, 2018 continued collecting on the seven defined core performance measures which were selected as the foundation for program evaluation. Those measures and their operational definitions can be found below. Any formal changes or additions will be captured in subsequent reporting.

In addition to the outcome evaluations and data being collected by the team, there is a quarterly evaluation table that is submitted to the IDN Program Director. It includes the following:

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of Medicaid women successfully completing the IOP program		Program Not Started	N/A	7
Number of women engaged in continuing care one month following completion of IOP			N/A	7 (All require other level of care)
Number of negative UDS at end of program			N/A	2
Number of women receiving reproductive health services visit			89%	100%
Number of pregnant women who attend recommended prenatal visits during program			100%	100%
Number of women with established PC relationship			78%	58%
All program participants are screened for SDoH			78%	89% received screener, all meet with resource specialist
<b>STC Defined Program Measures</b>				
<i>All performance measures identified within the evaluation plan milestones</i>	100%	100%	100%	100%

<i>Operationalization of Program</i>				
A. Implementation of Workforce Plan				
B. Deployment of Training Plan				
C. Implementation of any required updates to clinical protocols, or other operating policies and procedures				
D. Use of assessment, treatment, management and referral protocols	100%	100%	100%	100%
<i>Initiation of Data Reporting</i>				
A. Number of individuals served vs. projected			75%	75%
B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected			100%	100%
C. Impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	100%	100%	100%	100%

Details of the Reporting Measures: July-December 31, 2018

<b>PATP-IOP Expansion Program Performance Measures</b>	<b>Cumulative to 6/15/18</b>	<b>Cumulative to 9/30/18</b>	<b>Cumulative to 12/31/18</b>	
<b>1) Number of women successfully completing the IOP program</b>	0	2	7	Defined as 22 visits in 18 weeks
<b>o Completion is: 22 sessions completed within an 18 week period</b>				
<b>Number of women currently enrolled</b>	5	3	5	
<b>Number of women discontinuing program prior to completion*</b>	4	8	9	*Each IOP treatment episode is reported separately; but patient will not be counted as discontinuing program if stopped IOP for residential placement and then restarts new IOP episode
<b><i>If discontinuing program, disposition:</i></b>				
<b>Office based treatment</b>	1	3	4	1 transfer, two individual treatment plans at OP level
<b>Residential treatment recommended, treatment status unknown</b>	1	5	1	
<b>Residential treatment confirmed</b>	1	0	2	
<b>No known treatment on discontinuation of program</b>	1	5	2	
<b>2) Number of women engaged in continuing care one month following completion of IOP</b>	N/A	1		*Measure specifies <b>after completion of IOP</b>

o Continuing Care is:				
§ Return to OP level of care		0	5	
§ Transfer to other OP or IOP		0	1	
§ Discharge to higher level of care		1*	1	*1 awaiting residential placement; 1 discharged, disposition unknown
3) Number of women with negative UDS at end of program*	N/A	0	2	
o Less than 50% testing positive for THC by the end of an IOP		0%	29%	% positive for THC
o Less than 25% testing positive for any non-prescribed substance other than THC		100%	43%	% positive (alcohol, fentanyl, or methamphetamine)
4) Number of women receiving reproductive health services visit				
o Health Services visit includes:				
Hepatitis B screening*	67%	62%*	68%*	* ordered= 100%
Hepatitis C screening*	67%	62%*	68%*	* ordered= 100%
HIV screening*	67%	62%*	68%*	* ordered= 100%
Chlamydia and gonorrhea screening	89%	85%*	89%*	*1 declined
§ PAP history reviewed, updated if indicated	89%	100%	100%*	* 2 did not receive recommended follow up
5) Number of pregnant women who attend recommended prenatal visits during program*	100%	67%	100%	n=5
6) Number of women with established relationship with a primary care	78%	62%	58%	
o At least one visit with a PCP in the past 12 months	67%	46%	53%	
7) All program participants are screened for Social Determinants of Health*	78%	77%	89%	Not all patients received SDOH screener, but all met with Resource Specialist for assessment. <b>Proportions represent patients assessed positive through either SDOH screening and/or assessment.</b>
o SDoH assessment includes identified concern for:				
§ Housing	29%	46%	41%	
§ Financial Strain	86%	85%	82%	
§ Education	0%	0%	0%	
§ Social Isolation	29%	23%	18%	
§ Transportation	86%	92%	76%	

§ Employment	43%	38%	41%	* Includes legal issues known to be present for patients who reported "no" in SDOH screener (=31%) *Proportion reporting current safety issues
§ Legal Issues	43%	69%	58%*	
§ Interpersonal Safety	71%	54%	42%	
o Data pull will include # of positive screens, % month to month, domain area with highest + screens quarterly, annually				

### D-3. IDN Community Project: Workforce Staffing

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

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

See below for quarterly submission of attestation by project team:

Attestation of Staff Time		
Current Quarter Dates:	Oct – December 31, 2018	
Name of Staff	% Time	Attest to Accuracy Y or N

[REDACTED]	35%	Y
[REDACTED]	30%	Y
[REDACTED]	10%	Y
[REDACTED]	40%	Y
[REDACTED]	30%	Y
[REDACTED]	50%	Y
[REDACTED]	10%	Y

#### D-4. IDN Community Project: Budget

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

Updated projections for the PATP/IOP D3 project through CY2021. These budgets have been constructed to include all known components of IDN projects to date by CY but is subject to change as more details are determined in the upcoming implementation periods. Additionally, as IDN1 project subcontracts are created on implementation year and these focus on CY the balance of funds is slightly variable.

#### REDACTED TABLE

Updated Expenditures and Budgeted Line Items as of 12/31/18

Overview Financing to Date			
	Budgeted Amount	Actuals Spent in Quarter 10/1/18-12/31/18	Actuals Spent to Date 12/31/18
Staffing	\$239,085	27919.52	132036.65
Fringe Benefits	\$82,245	8542.87	38797.09
Purchased Services (Recovery Coach Salary)	\$14,000	5437.50	\$2,987.50
Supplies	\$10,000	\$0.00	\$789.54

#### 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.

[REDACTED]	Agreement Executed (Y/N)
[REDACTED]	Y
[REDACTED]	Y
[REDACTED]	Y

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

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project.

No change in the January-June, 2018 semi-annual period to the assessments used by the clinical team for the IOP cohort. Potential expansion of tools used will be included in subsequent reporting periods.

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

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

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

### **Updates as of December 31, 2018:**

The PATP-IOP project team worked diligently throughout fall, winter 2017/2018 in preparation for the expansion to 3 weekly clinical days to support the PATP IOP. Much of this work centered on process mapping and workflows for new patient referral, daily treatment flow, and new process development. With the support of the QI facilitator from CHI, the team was able to use process improvement tools to streamline and formalize this work. Two formal protocols born out of this work were the IOP treatment contract and the formal IOP curriculum. Both tools are based on pre-existing PATP OP frameworks, which, in turn, are derived from evidence-based best practices used at similar programs throughout the country. They blend the strongest components of each project structure to suit the particular needs of this specific population and the culture of the PATP program.

The PATP-IOP went live with a patient pilot group in the IOP in early spring, 2018. This small cohort launch has allowed the clinical team to work through ongoing process improvement to the development of patient pathways and protocols. At this point in project development the team has a robust collection of IOP materials, workflows and protocols.

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

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

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

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

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

**Therapeutic effectiveness guidelines:**

- 1) Buprenorphine will be prescribed as part of an overall effort to help people become abstinent from opioids. The goal of treatment is total abstinence from all drugs of abuse, including alcohol and marijuana.
- 2) All patients will provide a point-of-care urine sample for a toxicology screen for substances of abuse and buprenorphine prior to receiving a prescription for buprenorphine. This urine sample may be observed by a staff member.
- 3) Urine samples will be periodically sent out for confirmatory testing, which may include testing for alcohol metabolites, bath salts, or other illicit substances.
- 4) It is a felony in NH to obtain a prescription using deceit, so any adulteration of urine specimens will be considered to be the commission of a crime on premises. As such, confidentiality rules such as 42 CFR Part 2 and HIPAA do not apply. We reserve the right to immediately discharge patients and notify law enforcement if urine specimens are adulterated.
- 5) The frequency of treatment visits will be determined by the treatment team. Generally patients should expect to be seen weekly for the first 9-12 months of treatment. At that point, patients who are stable in treatment (including no use of alcohol or marijuana) may decrease the frequency of visits to every other week, and eventually monthly. If drug use is reported or detected, the patient will be seen weekly again until stability is achieved.

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

**Program efficiency:**

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

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

- 5) Patients are responsible for maintaining insurance or completing paperwork for financial assistance if they cannot afford the fees associated with care.
- 6) Patients who chronically overuse our support staff's time by repeatedly calling with the same issue or who call the emergency line with non-emergency concerns (such as inquiries about appointments or buprenorphine refill requests) may be discharged from the clinic.
- 7) Missed or refused urine drug screens are presumed to be positive for illicit substances and this will be documented in the patient's chart.
- 8) Program staff are mandated reporters and are required to report concerns about the abuse or neglect of a child to child protection in the patient's state of residence. Missed visits and positive urine drug screens may contribute to concern about the abuse or neglect of a child. Whenever possible, program staff will notify a patient if a mandated report is required.
- 9) Patients are encouraged to sign releases of information for other agencies involved in their care (e.g. DCF/DYCF, other medical providers, probation & parole, etc.). We cannot agree to provide "partial" information in these situations, such as withholding urine drug screen results.
- 10) Pregnant patients must present proof of pregnancy and an estimated date of delivery.
- 11) Staff will have one full business day (24 hours) to return phone calls and do prior authorizations.

**Avoidance of diversion:**

- 1) The total dose of medication will not exceed 16 mg for any patient.
- 2) Please note that this clinic has taken the position that buprenorphine-naloxone (**Suboxone**) is an appropriate medication for most pregnant women. Patients who are prescribed buprenorphine-only preparations (**Subutex**) during pregnancy will be immediately transitioned to buprenorphine-naloxone preparations following delivery.
- 3) Patients must pick a "home pharmacy" and sign a release of information for that pharmacy.

## D-8. IDN Community Project: Member Roles and Responsibilities (*No change July-December 31, 2018*)

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

No change since full staffing as of July-December, 2017 reporting:

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

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

**D-9. Provide the training plan and curricula for each Community Driven Project as required in A-1.3 (No change July-December 31, 2018)**

Given that the PATP-IOP team has been operational since fall of 2017 and fully staffed as of December, 2017 the team has completed all of the preliminarily identified trainings needed for IOP launch- with additional trainings being included as needed or identified by staff role. The culture of the PATP is that ongoing training is a standard, and, as learning opportunities come up and interested staff are available



## Project Scoring: IDN Community Project Process Milestones

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

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

## Projects E: Integration Focused

### IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

*See Appendix E-1 for Excel Workplan of E5 Activities*

*IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.*

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

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

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

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

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

#### Overview of the E5 Project Team Restructuring: As reported in June-December, 2017 SAR

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

Core Process Milestones:

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

Given significant capacity limitations within the internal team designated to steward the coordinated entry project, there were significant delays to the project development. The core team at VRH worked to move forward with project process milestones their limited bandwidth allowed. The team successfully met bi-weekly throughout the fall and early winter, 2017. In mid-December, 2017 the project team, senior leadership at VRH, and members of the B1 team met for a 90 minute session to brainstorm next steps for the project. This meeting yielded some positive reframing but given continued ambiguities in regard to project implementation, the project team suspended meetings to allow for IDN restructuring. The IDN and QI support have been meeting through late December to review the project process thus far and think about potential areas for change:

#### **Areas of Project Success:**

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

#### **Areas of Challenge:**

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

### Alternative Ideas and Ways to Move the Project Forward:

- IDN and Continuum of Care hosted transparent conversation with all community partners at the CPM meeting on February 7, 2018
- Allow community partners to identify areas of forward movement within the scope of work and use community knowledge to reframe and re-implement the project in Sullivan County
- Assess capacity and ability to host hiring and job posting to go through the IDN/ TDI/ DH
- Re-evaluate job description and determine minimum requirements to be beneficial to project
  - Assessment of licensure level needed
  - Benefits of a licensed social worker vs areas that can be filled by a lower level staff individual
- Opportunity for IDN funded administrative support and/or project management
- Work with VRH to assess for any areas of internal capacity for project ownership and support
  - Integration with B1 VRH/CA pilot
- Identify tools and systems that increase communication between project team, IDN, and UNH facilitator
- Assess options for further involvement of the community, potential development of a community advisory board
- Look at opportunities for hiring to originate from City of Claremont or others
  - Explore co-leadership for the coordinator position with VRH and another City organization
- Review project catchment area and expand for access in Newport, Claremont etc.- Sullivan County
  - Opportunities to coordinate with the Sullivan County CoC staff hired at DH
- Explore opportunities for lower level licensure to fill the CTC position and case examples
- Opportunity to link the CTC to B1 and use the MDCT as the referral source for patients to the E5
- Review supervision components and explore alternative options for coordination to provide supervision
  - Core components
  - Support requirements to the staff person
- Review caseload volumes and function
- Organizational assessment of behavioral health organizations- opportunities for linkage
- Speak to the DOC for coordination into a care management community network at point of release or discharge
  - Link to VRH for PC
    - Push to community supports network
    - IDN1 will be connected to the DOC for coordination
- Opportunity to use MCO data to pull patient panel and support identification for the community networks
  - Address capacity to link up to the ECC provided by MCOs and align with IDN projects

### Lessons Learned:

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

### What can the IDN offer in support?

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

### What is needed from a hosting agency?

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

The restructuring and review of the E5 project is still underway with the IDN1 team, QI support, and CoC representative from Sullivan County.

### Updates as of July-December 31, 2018:

Since early summer, 2018 the E5 project steering group, comprised 2 CHI Coaches, the Sullivan County Substance Misuse Coordinator, SCCT Project Facilitator and as needed guest attendees. The facilitator was hired in late spring, 2018 under the below SOW table

<b>Task / Responsibility</b>	<b>Details</b>	<b>Time Required for Task Completion</b>
<b>Bi-Weekly Meetings</b>	Held twice monthly with All Partners	2 hours / month Travel Set Up Time
<b>Prep Call w/ IDN / CHI Team</b>	To prep for Bi-weekly meeting	0.5 hours / month
<b>Coordination of All Partners Meeting participants</b>	Schedule meetings, secure meeting space, communicate with partners	1.5 hours / month
<b>Support Partner Expansion and Inclusion</b>	Reaching out to new partners, communications with new partners	.25 hours/month
<b>Voice of the All Partner Group</b>	External messaging, in support with the IDN and CHI.	.25 hours/month

The group has been working to support the Complex Care Team (SCCT) membership to identify their goals and layout a roadmap for shared patient review. The group continued supporting monthly sessions with the full membership as well as small work sessions and steering committee meetings to guide the flow of work. See below for a mission driven one pager to guide the SCCT membership and new partners;



# REGION 1 IDN OVERVIEW

# PARTNERSHIP FOR INTEGRATED CARE

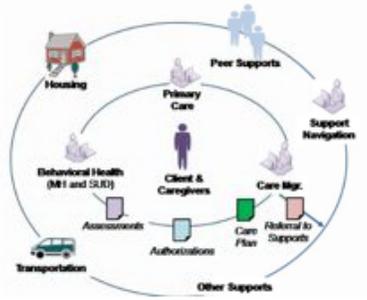
**Overview**  
The Region 1 Integrated Delivery Network (IDN) is a partnership of almost 50 stakeholder organizations across the Upper Valley, Sullivan County, and the Monadnock Region committed to transforming the delivery of behavioral health services for Medicaid recipients by:

- Integrating physical and behavioral health care
- Expanding capacity to address behavioral health needs
- Reducing gaps in care transitions across care settings

Our diverse group of partners include:

- Advocacy groups
- Housing agencies
- Transportation services
- Municipal offices
- Clinical providers
- Substance use disorder centers
- Mental health workers

We embrace patient and family-centered care and want to foster collaborative and innovative pilot programs. We are hoping to advance integrated behavioral health and primary care service efforts in our region.



### Administrative Team

Ann Landry, MBA, Executive Director  
Peter Mason, MD, MPH, Medical Director  
Jessica Powell, MA, Project Manager

### E5 Project Team

Jessica Powell  
Ashley Greenfield  
Stacey Hammerlind



Following feedback sessions in spring, 2018 a small group of 8 SCCT members was pulled together to review the following draft of a formatted referral document;

regi n1 CITIZENS HEALTH INITIATIVE Case # \_\_\_\_\_

**Community Care Team (CCT) Case Consultation Form**

Date: 6/22/2018  
 Agency POC: \_\_\_\_\_  
 Agencies Present: LIST AGENCIES IN ATTENDANCE AT THE CCT MEETING

**Demographic Information:**

Household Members:	Age	Gender	Ethnicity/Race	Employment	Education	Marital Status	Primary Language

**Income/Expense Sheet**

Monthly Income	Monthly Expenses

**Presenting Concerns (Check all that apply):**

Housing	Utilities /Bills	Childcare			

Notes:

regi n1 CITIZENS HEALTH INITIATIVE Case # \_\_\_\_\_

**Current Services and Supports:**  
 Is the family/individual currently working with other providers, community agencies, or natural supports?

Agency Supports		
Agency	Type of Services	POC
School _____		

Natural Supports	
Relationship	Type of Support

**Identified Strength(s):**  
 What strengths has the client identified? What strengths do you identify?

**Primary Case Consultation Question/Concern:**  
 What are the primary concerns you are bringing to the Case Consultation Team (CCT)? What are the most pressing issues? How can the CCT assist?

The form was first shared with the SCCT during the first week of August, 2018. This session of the SCCT commenced the first review of a de-identified case using the template format. This shift not only introduced the form and process to the SCCT group but marked a significant split from the All Partners meeting- the large stakeholder meeting run by Southwestern Community Services from which the membership for SCCT was formed. The August, September, and October sessions of the SCCT were pilots of de-identified case discussions initially co-led by the steering committee and ultimately concluding in meeting leadership with the SCCT facilitator. Unfortunately, due to many family circumstances and additional professional obligations the contracted facilitator has struggled to attend consistent meetings throughout the fall, 2018. The E5 steering membership have re-resumed many of the facilitator roles and are reviewing next steps in regard to the contracted position.

Additionally, with support from the SCCT membership the draft document shared above has been through many revisions and refinements to tailor to the flow and needs of the group.

The SCCT has experienced several challenges throughout the July-December term related to sharing of de-identified case information. Many of the partners feel insecure in their understanding of the privacy regulations and wary of sharing even de-identified information. Additionally, the process to determine how to select cases that meet the high acuity targets set forth by the group early in CY2018 but not those that need more immediate assistance and support has been reported as a barrier.

Another issue in the early months of the quarter was related to the timing of the meeting. For many of the direct service providers who comprise the SCCT membership being out of the office for two back to back meetings is difficult. After polling membership the decision was split and the meeting time has not been changed but there is still some inconsistency in attendance from month to month.

At the outset of project proposal the group was targeting creation of a multi-organization consent form to enable identified patient information to be shared but after initial privacy conversations and support from IDN1 legal contractors the group is revisiting the feasibility and timing for execution. A follow up legal session supported by Lucy Hodder of UNH is planned for the first week in February, 2019. The steering committee will pull together a series of small work sessions with targeted membership of the larger SCCT to brainstorm next steps and feasibility. Given the diverse nature of the participating organizations membership are affected by HIPAA, 42 CFR PT. II, FERPA, VAWA, HUD regulation etc. These guidelines vary in their parameters, requirements which adds additional layers of complexity to the development. Additionally, given the varying nature of type, size, and culture of the organizations participating it is clear that there is significant work to be done to level set the membership on their particular privacy needs. The E5 steering group has been working to reach out to the legal staff and leadership at the primary SCCT organizations to assess need and discuss next steps.

In December, 2018 following 1 de-identified case presentation the QI coach led the group some exercises to draw out and clarify the primary privacy concerns, questions and areas of interest. This exercise has helped to inform the development of the presentation materials for Lucy H’s February presentation.

Following the conclusion of the privacy discussions in February/March, 2019 and the ongoing review of the closed loop referral application, UniteUS, potentially applicability with the group it is anticipated that the SCCT membership will feel prepared to define their remaining implementation period targets. The hope is to formalize these efforts in a work plan and accompanying scope of work that not only outlines the implementation needs but specifies the project ownership and sustainability plan in Sullivan County.

## E-2. IDN Community Project: Evaluation Project Targets

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

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

Given the early stage of project restructuring the large SCCT group has not had the opportunity to discuss project evaluation and the below are draft measures.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of Cases Reviewed by the SCCT	24 Cases (Annual)	N/A	N/A	6- Given the restructuring of the SCCT model and case review approach the volume for case reviews has been smaller than anticipated. The group spent the better part of CY2018 getting an operational referral flow, case presentation format and forms in place. Additionally, the ongoing privacy and culture shift by each organization has taken precedence to the # of cases reviewed each session. As of re-submission the team has reviewed 10 cases and is moving forward with monthly case sharing. (Unmet)

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
SCCT Referrals Made and Closed	100%	N/A	N/A	<p>Not yet tracked due to privacy and lack of multi-party consent</p> <p>As the group has moved forward with a de-identified mode of case sharing and the referral connections are made once consent has been established from the presenting organization to the patient and authorizing the new organization inclusion into the care team there is not yet an opportunity to track direct referrals from the SCCT. The group will be working on defining measures and tracking for established progress at the March, April sessions. (MET)</p>
Expansion of SCCT Membership	40 Organization	N/A	N/A	<p>Addition of the following; Newport Health Center, NLH Representation, VRH representation, Valley Primary Care.</p> <p>The current list serve of organizations invited to each session is in excess of 40 organizations- the attendance varies by session. (MET)</p>

### 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.

Given the change in project model from a VRH held position to a community focused multi-organizational community effort there is not yet a large enough body of recurring work to specify the need for % FTE. To accommodate for the shifting project nature and the development the group has identified need for facilitation and project management to support the participant organizations to continually progress toward a sustainable monthly complex care team. The current contracted 5 hours monthly has allowed for this level of effort to be maintained. In CY2019 this may shift dependent upon the continued pursuit for adoption of a multi-party consent form or if that effort will be discontinued in favor of a more immediately sustainable de-identified case sharing process in pilot currently.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
SCCT Facilitator	.5 FTE	N/A	N/A	Consultant Hired for Contract Hours up to 5 hrs. per Month	Consultant Hired and In place for 5hrs Support Monthly <b>MET</b>

### E-4. IDN Community Project: Budget

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

No current project expenditures to date. Updated budget expenditures will be shared in the July-December, 2018 SAR. The current model is only incurring costs for the contracted SCCT facilitator's time and drawing down on the contracted QI coaching hours previously contracted with CHI.

No change in the July- December, 2018 term. The team anticipates onboarding the Closed Loop Referral application UniteUS as a pilot sub-project with this group in early 2019. Costs incurred are estimated at about \$60,000 annually dependent on volume of organization participation.

Previous expenditures for the E5 Coordinated Entry Project are reflected below as well as the E5 payments made to the C1/E5 Co-Pilot project as of December 31, 2018:

Enhanced Care Coordination	- Total:	\$186,554
[REDACTED]		[REDACTED]
[REDACTED]		[REDACTED]

Due to the current stage of implementation and deployment of the restructure E5 in Sullivan County for the Sullivan County Complex Community Care Team the IDN does not have enough understanding of how the project will be reseeded within the community organizations at time of reporting to project out expenditures through 2021. The E5 budgeted funds for overarching project category can be seen in the PPI budget on Pg. 11.

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

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

**REDACTED FINAL**

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

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

Given that the SCCT is functioning out of a pre-established network grouping there are not currently formal agreements in place with any of the participating organizations. As the project development progresses there will be executed consent forms will be executed with all of the participating organizations to facilitate identified case sharing. Additionally, it is the ultimate goal to re-seat project ownership within a Sullivan County-- based organization, at which time a subcontract agreement will be executed for project funding. Updates on the progress of these two formal agreements will come in subsequent reporting periods.

Given the nature of the SCCT group a formal agreement executed with the IDN is not needed. Many of the organization participants are direct members of the IDN network who have signed agreements for generalized project work. Additionally, all of the organizations listed are monthly involved in all SCCT communication, updates, meeting invites and case development.

Organization/Provider	Agreement Executed (Y/N)
Baby Steps	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Children of Incarcerated Parents	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
City of Claremont	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Claremont Chamber of Commerce	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Claremont Connect Center	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Claremont Soup Kitchen	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Colby-Sawyer College	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
DCYF	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Department of Corrections, Sullivan County	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
DHHS	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation

Episcopal Curate of Sunapee St. Andrew's, New London, NH, Epiphany, Newport, NH	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Fall Mountain School District	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Greater Sullivan County PHN	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Green Mountain Children's Center	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Groups	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Groups	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Headrest	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Kearsarge School District	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Lake Sunapee VNA and Hospice	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
New London Hospital/Newport Health Center	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
NH Employment Services	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
NH JAG	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
One for All SAU 6, Claremont	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Pathways	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Planned Parenthood	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Regional Access Points	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
River Valley Community College	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation

SAU 43- Newport	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
SAU 6- Claremont	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Second Growth	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Servicelink	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Shining Success	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
South Congregational Church, Newport	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Southern NH Services	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Southwestern Community Services	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Sullivan County United Way	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Sunapee School District	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
TLC	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Tri-County Community Action	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Turning Points Network	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
UNH Cooperative Extension	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Valley Regional Hospital	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Vital Communities	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
West Central Behavioral Health	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Valley Regional Hospital	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation

GROUPS Recover Together	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
Southwestern Community Service	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation
SAU-6 FAST Forward 2020	N/A : Y agreement to continue receiving updates on SCCT and optional direct participation

## 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*

*No formal change in July-December, 2018:* Given the early stage of project reconstruction the SCCT has not yet determined case assessment tools. It is anticipated that the group will look to use pre-existing community care team assessment standards as a guideline for the group’s materials and tools development.

The SCCT membership are discussing tools targeted at assessing for Social Determinants of Health. This conversation is being supported by the group membership operating within IDN1 funded B1 projects. As many of the membership organizations are very small community support agencies they have standard intake forms but are not familiar with screening or risk stratification scores. This is one parallel path for the group to continue to explore interest in as the team works to build a cadence and flow around complex care management.

**See the screenshot of the case review form in use shared above. Additionally, given the nature of the SCCT in its current format there may not be need for a more formal process for assessment within the group. As the case review form (see above) will allow the group to bring cases, address need and target next steps.**

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

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

*Updates as of December 31, 2018:*

The IDN1 Administrative team is continually working with the SCCT E5 group to document their newly developed Care team protocols. The group currently has protocols in place for:

- Case Identification and Submission
- Submission Review by SCCT Facilitator
- De-Identified Case Presentation
- *In development:* De-Identified Case Follow-up

- *In development:* Case Restrictions and Presentation Guidelines

However, given that the current de-identified case sharing is an interim process as the SCCT defines their target scope for complex case sharing these protocols/workflows/guidelines are lean and not anticipated to be more formally developed.

As shared above the development of SCCT protocols hinges primarily on what information is able to be discussed openly amongst the large group membership. Until final decisions are made regarding the nature of the consents being used by the group there will not be formal development of SCCT protocols and forms.

**As the structure of the group SCCT is set up as a triage platform for case review and as a coordination effort to link complex cases will all available, applicable providers there is no clinical assessment that will take place. Nor is there treatment or management outside of the established case treatment plan created by the**

### E-8. IDN Community Project Member Roles and Responsibilities

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

Project Team Member	Roles and Responsibilities
[REDACTED]	Contracted Facilitator Responsibilities: Receipt of Case Referrals, SCCT Case Review Facilitation,
[REDACTED]	Substance Misuse Coordinator Support Responsibilities: Partnership Management and Project Support
[REDACTED]	Contracted QI Coach Responsibilities: Quality Improvement and Project Support
[REDACTED]	Contracted QI Coach Responsibilities: Quality Improvement and Project Support
[REDACTED]	Project Manager Responsibilities: Project Management Support

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

Given the early state of project restructuring there has been no determined training or curriculum for the E5 SCCT beyond the developed materials shared in section E-1. It is anticipated that there will be a session dedicated to identifying training needed to support the transition to identified case sharing. Additionally, identification of any supportive trainings on large group care team dynamics, information sharing and case review are being pursued by members of the SCCT steering group.

In the July-December, 2018 the vast majority of E5 SCCT membership took part in the Motivational Interviewing, Addiction 101 and the Behavioral Health summit trainings as offered by the IDN. These trainings have brought an increased level of education, expanded tools and materials that the group has put into use across the service delivery continuum in Sullivan County.

## DHHS Project Scoring: IDN Community Project Process Milestones

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

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

## Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

Lynn Guillette, VP of Payment Innovation at Dartmouth Hitchcock and Chair of the IDN1 Executive Committee, has been named the primary IDN1 APM liaison for the DHHS sponsored APM workgroup. Lynn, one of the leaders in the state on alternative payment models, has been integrally involved in IDN1 activities since the projects inception and served on the Exec. Committee and as chair of the IDN1 Finance Committee. The IDN1 Finance Committee under Lynn's leadership in January/February, 2018 has been relaunched to shift focus to determining the regional APM strategy and tracking alignment to the statewide plan developments.

Given the current status of the statewide APM roadmap the IDN1 team is also in the beginning stages of plan development. IDN1, along with other IDNs, are watching the MCO procurement carefully to better understand what the shared responsibility between MCOs and the IDNs will be in developing the APM strategy and defining the "50%". The IDN1 team feels that with the workgroups strong membership and regional knowledge expertise this group will be successful in driving the regional plan forward and maintaining coordination with statewide efforts even in the short timeframe required. Additional information on the regional IDN1 APM plan development will be available in subsequent SAR reports.

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

*Provide a brief narrative describing the current use of APMs among partners.*

*Use the format below to: identify the IDNs participation in workgroups for the development of the DSRIP APM Implementation Plan; assess the current use and/or capacity for engaging APMs amount IDN participants; develop an IDN-specific plan for implementing the roadmap to include IDN-specific outcome measures; and develop the financial, clinical and legal infrastructure required to support APMs.*

Currently in IDN1 there are several organizations accessing APM structured contracts with NH state insurers of Medicaid recipients. Most notably are those pre-existing contracts with the Community Mental Health Centers; West Central Behavioral Health and Monadnock Family Services. As well as those between hospital systems such as Dartmouth-Hitchcock through their ACO work and contracted services.

At this point in state IDN APM development there are no IDN1 partners with APM contracts. The IDN1 team is staying tightly connected to the MCO Procurement process and aligning where possible to extend the

current APM structures in place with network partners and addressing new areas of coordination. Additionally, the IDN team is staying closely involved with the development of the DHHS APM Roadmap to guide new APM opportunities for our network partners.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Met	Met	Met
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures	Met	Met	Met
Develop the financial, clinical and legal infrastructure required to support APMs	In Process, Fully Supported by IDN1	In Process, Fully Supported by IDN1	In Process, Fully Supported by IDN1
Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal and clinical preparedness and engagement with MCOs	Met	Met	Met

## DSRIP Outcome Measures for Years 2 and 3

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

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

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

## Appendix A1-3:

Deliverable/Milestone	Oct	Nov	Dec	2019	2020	Status	December 2017 Notes	June 2018 Notes	December 2018 Notes
<b>Pre-Work</b>									
<i>Continued Participation in Statewide BHWT</i>						Ongoing	Continued Statewide Collaboration in small groups and at the taskforce level		
<b>Deliverable: Submission of Statewide BHWT Strategic Plan</b>						Completed			
<b>Deliverable: Signed Attestation of IDN Review and Acceptance of BHWT SP</b>						Completed			
<b>Signed by Peter M. and Will T. as Region 1 Representatives</b>						Completed			
<b>Implementation Plan</b>									
<b>Gap Analysis Development with C/WWG</b>						Completed			
<b>Deliverable: Gap Analysis Narrative Submission</b>						Completed			
<b>Timeline</b>									
<b>Deliverable: Implementation Timeline</b>						Completed			
<i>Phase 1 : Through December 2018 (Detailed)</i>									
<i>Phase 2: End of Implementation Plan (High-Level)</i>									
<b>Milestones</b>									
<b>High level Milestones through 2020</b>									
<b>Deliverable: Milestones Timeline</b>						Completed			
<b>Evaluation Metrics and Targets</b>									
<b>Deliverable: Identify measurable targets and goals to align with Milestones timeline</b>						Completed			
<b>Strategy Development</b>									
<b>Deliverable: Workforce Capacity Development Strategy</b>						Completed			
Address Education and Training Completion to Readiness									
Address Data/Initiative inventory assessment									
<b>Staffing/ Recruitment</b>									
Identify FTE needs across A2, B1, C1, D3, E5						Completed			
Include Workforce FTE strategy and Projections for unknown areas						Completed			
<b>Deliverable: Fill SA Staffing Table</b>						Completed			
Share Table with All Project Partners and AC						Completed			
Schedule HR Meeting with Region 1 IDN Partners						Completed			
HR Meeting with Region 1 IDN Partners: Address data sharing, recruitment, cost of hiring, position vacancies						Completed	Met with a few partners individually; Met with multiple partners during November and December workforce meetings; HR meeting scheduled for January was pushed back to February	Conducted HR meeting in February which served as a training for best practices for behavioral health workforce recruitment and retention strategies.	
Schedule Meeting with IDN Partner Clinical Directors and Center for Technology in Behavioral Health at DH						Completed			
Clinical Partners and CTBH Meeting on innovative recruitment and utilization of remote clinicians						Completed			
Support creation of a Teleconferencing Supervision Committee to address potential for group and teleconference based clinical supervision						Completed			
Regional Job Fair, 2017: Targeting students graduating in Spring of 2018 (Recurring 1x Annually) <b>Change Deliverable: Leverage and communicate about existing job fairs in each sub-region to ensure partners are represented at them to promote behavioral health positions</b>						Completed	IDN is working with partners to select spring time date; IDN is also working with all other IDNs on a statewide strategy to celebrate behavioral health sector which would include job fairs and mental health days	Region 1 IDN Workforce Workgroup didn't wish to hold a Region 1 IDN specific job fair. Partners struggle with the effectiveness of job fairs in general, attending only out of obligation and the ROI may result in one new applicant. The group recommended leveraging existing job fairs, communicating existing job fairs, exploring an all – IDN virtual job fair and participating in a statewide job fair if hosted.	Reached out to partners for existing job fairs and circulated information among our partners; follow up on the statewide workforce; Peter participates in the Primary Care Commissioner meetings; engaged with Bi-State, IDN 1 funded partners are paying for Bi-State consultation as well





	<b>Deliverable: Table of Key Organizational and Provider Participants</b>								Completed			
	<i>Include Partner List across all Projects (A2, B1, C1, D3, E5)</i>											
	<b>Retention</b>											
	Training Program Development: Address Culture of change and integration of the cultures of physical and behavioral health								Completed			
	Schedule Community forums in each sub-region of the IDN 1 Catchment: Follow similar model to Mental Health Day Program at DHMC <b>Change Milestone to Leverage existing community forums in each sub-region to promote mental health awareness and inform about the IDN work; partner with other IDNs on a statewide approach</b>								Completed & Ongoing	Region 1 focused on recruitment and staffing for projects during this past reporting period, deciding to move the Community Mental Health forums to the spring. Additionally, Region 1 is creating an overarching social marketing strategy/campaign for the region which will include Community Mental Health Forums as well as align to the statewide workforce taskforce behavioral health celebration and job fairs	Partners represented on the Region 1 IDN Workforce Workgroup determined that IDN sponsored community forums would be redundant and a poor use of resource. The group recommends leveraging and supporting existing community forums to celebrate progress and mental health/SUD. Additionally, the group believes that this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan.	Statewide celebration occurred at the NH Behavioral Health Summit in December. IDN 1 helped to plan and sponsor the IDN training track. We align the public health networks in our sub-regions; IDN is present; we leverage existing community forums; health equity; substance misuse
	Schedule meetings with regional community mental health providers: Target level of supportive funding to provide necessary support for career advancement and reduce burn-out								Completed			
	Target determining thresholds for Salary/Benefits through Monthly Knowledge Exchange Workforce Meetings								Completed			
	Activities by Workforce Workgroup to explore supportive funding synergies: philanthropy, development etc. - Quarterly Ongoing.								Completed			
	Supported Culture of Change Trainings for B1 Partner Agencies (available for all IDN partners) - Assess Progress Semi-Annually								Completed		IDN 1 will offer additional culture of change trainings in the latter half of 2018. In process of trying to identify other effective trainings that have been successful for other IDNs.	
	Supported Community Forum Meetings across IDN 1 - Assess progress Semi-Annually in 2018 <b>Change Milestone to Assess progress semi-annually in 2018 on success in Leveraging existing community forums in each sub-region to promote mental health awareness and inform about the IDN work; partner with other IDNs on a statewide approach</b>								Completed & Ongoing	Region 1 focused on recruitment and staffing for projects during this past reporting period, deciding to move the Community Mental Health forums to the spring. Additionally, Region 1 is creating an overarching social marketing strategy/campaign for the region which will include Community Mental Health Forums as well as align to the statewide workforce taskforce behavioral health celebration and job fairs	See Row 64. Partners represented on the Region 1 IDN Workforce Workgroup determined that IDN sponsored community forums would be redundant and a poor use of resource. The group recommends leveraging and supporting existing community forums to celebrate progress and mental health/SUD. Additionally, the group believes that this is a clear opportunity to partner with other IDNs to fund a statewide event as written in the Statewide Plan.	Statewide celebration occurred at the NH Behavioral Health Summit in December. IDN 1 helped to plan and sponsor the IDN training track. We align the public health networks in our sub-regions; IDN is present; we leverage existing community forums; health equity; substance misuse; also spoke at delegation and county commissioner meetings
	Developed and operational financial support plan will be in place with committed IDN funds- linkages to all other community based project budgets - Completed not later than June 2018								Completed			allocation of community support funds; targeted community support agencies for needed resources
	Operational IDN partner staff salary support addressing entry-level positions supplemental funding								Completed		Region 1 IDN offered \$137,500 towards Entry Level Position Support its Phase 1 Workforce RFA and approved all \$83,900 requested. This milestone will always be in progress.	
	Ongoing data evaluation and assessment of retention impact on the positions and organizations supported through the entry-level positions supplemental funding program								Completed & Ongoing			We receive quarterly reports and evaluations from our partners receiving workforce funds on impact and retention
	Additional supported community forums, emphasizing mental health topics will be scheduled as requested											see above - public health networks; substance misuse; county meetings with delegates and commissioners
	<b>Education Activities and Milestones</b>											
	Identification of partnering regional educational institutions interested in developing new, and enhancing existing, behavioral health training programs								Completed & Ongoing	Ongoing in conjunction with Statewide Workforce Training & Education Subgroup	Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC	Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC; t
	Region 1 IDN Meeting with NH AHEC: Strategy development about enhancing educating student health professionals in collaborative practice and team-based models of care								Completed			
	Region 1 IDN and Partner Meeting with NH AHEC: Development of a "Road Show" promoting behavioral health career paths- First Meeting Completed								Completed			

Region 1 IDN Meeting with NH BDAS, Recovery Coach Academy, Center for Excellence, and other IDN's: Strategy development to address expanding the pool of peer recovery coaches in the Region and across the State						Completed			
Region 1 IDN Develops assessment with partner organizations to assess capacity for expanded student and trainee internships, preceptorships, and electives						Completed	Workforce Workgroup and all-partner Workforce discussion continues to discuss this topic and how to facilitate increased capacity for students and "apprentices"	Region 1 IDN offered \$75,000 towards Internship Stipends and Organization Capacity to Support Internships in its Phase I Workforce RFA and approved all \$35,000 requested. The IDN is also always discussing how to sustain the ability to fund and support interns given the importance of fueling the pipeline while recognizing the financial cost and resource drain on organizations. This milestone will always be in progress.	partners have limited capacity due to financial and time constraints; no reimbursement; limited capacity of those qualified to supervise; etc. Region 1 issued a second RFA with additional funds to support internship stipends and organizations' ability to support interns.
Functional workgroup of participating student and trainee internship supported agencies - Meeting quarterly						Completed & Ongoing	discussed how to financially support IDN partners with encouraging internship opportunities - both funds to support intern stipends and funds to support organizations to train/supervise interns. However, Region 1 has yet to release funds to partner	Region 1 IDN offered \$75,000 towards Internship Stipends and Organization Capacity to Support Internships in its Phase I Workforce RFA and approved all \$35,000 requested. The IDN is also always discussing how to sustain the ability to fund and support interns given the importance of fueling the pipeline while recognizing the financial cost and resource drain on organizations.	Get updates at workforce meetings; ongoing discussion; part of HR discussion; and receive quarterly updates from IDN-funded organizations on internship programs
Meetings held with administrative and behavioral health faculty staff at Keene State, New England College, Antioch New England, Colby-Sawyer College, River Valley Community College and Franklin Pierce University: Regarding educational programs to address regional workforce needs - Completion by June 2018						Completed & Ongoing		Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC	Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC
Coordinate meetings with IDN and NH AHECS- Address development of an inter-professional collaborative practice curriculum to be utilized by NH professional schools - Explore opportunities such as utilizing an interactive computer module.						Completed & Ongoing		Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC	Ongoing in conjunction with Statewide Workforce Training & Education Subgroup and leveraging existing work/relationships with AHEC; have \$25K to support it;
Creation of a comprehensive list of student and trainee sites developed and shared						Completed & Ongoing		Interns have just been brought on this summer through IDN - funding. Additionally, this should be a statewide goal.	Nancy Frank - statewide education and training - Sandy Blunt
Regional educational institutions involved in subsequent education activities will finalize identification of opportunities for new and expanded workforce development programs-Draft completion by December, 2018						Completed & Ongoing			Statewide Training & Education - Sandy Blunt
IDN supported additions to the student and trainee sites offered						Completed & Ongoing			Statewide Training & Education - Sandy Blunt
Continued development and progress on the inter-professional collaborative practice curriculum developed						Completed & Ongoing			See above
<b>Training Activities and Milestones</b>									
Region 1 IDN Meeting with B1 Providers- Address Workforce components of the Integration Project and IDN Supports						Completed			
Region 1 Supported information gathering to address partner desired trainings, current in house trainings, capacity for expansion, ability for new training creation, and the number of existing staff interested in each training category						Completed			
Offer trainings for Billing and Administrative Staff across all B1 partner agencies, other IDN interested partners, on mental health, SUD, and health literacy topics						Completed & Ongoing	To be started in 2018; looking at opportunities to align with Statewide Taskforce and other IDNS	Region 1 funded West Central Behavioral Health to offer 6 Mental Health First Aid Trainings in the Upper Valley and Sullivan County in 2018. Region 1 is working with Monadnock Family Services to offer a series of Mental Health Awareness trainings across the entire region.	Region 1 funded West Central Behavioral Health to offer 6 Mental Health First Aid Trainings in the Upper Valley and Sullivan County in 2018. Region 1 is working with Monadnock Family Services to offer a series of Mental Health Awareness trainings across the entire region. Ask Phil
Offer trainings for clinical staff on Universal SBIRT usage and Motivational Interviewing						Completed & Ongoing	All of our partners have access to the CHI/JSI SBIRT MI Initiative but we will encourage further training in the next year	All of our partners have access to the CHI/JSI SBIRT MI Initiative but we will encourage further training in the next year. Additionally, Region 1 has an Intro to MI training on July 25th and then a two part training scheduled for September 25th and October 2nd.	All of our partners have access to the CHI/JSI SBIRT MI Initiative but we will encourage further training in the next year. Additionally, Region 1 has an Intro to MI training on July 25th and then a two part training scheduled for September 25th and October 2nd.
Schedule trainings for assessing MAT expansion capability across IDN partner primary care sites - Assess progress across providers						Completed & Ongoing	Medical Director is currently piloting program at the Multispecialty Clinic at Alice Peck Day Memorial Hospital.	Medical Director is currently piloting program at the Multispecialty Clinic at Alice Peck Day Memorial Hospital and about to roll out to primary care practices across the state.	Medical Director is currently piloting program at the Multispecialty Clinic at Alice Peck Day Memorial Hospital and about to roll out to primary care practices across the state.
Support trainings for all Pt 2 providers on updated 42 CFR Pt. 2 requirements- Align with any Statewide or Learning Collaborative supports - Assess progress across providers						Completed			
Region 1 Meetings with Center for Behavioral Health Technology to explore use of telehealth models; Expanded treatment capacity and leveraging in-region BH expertise - Assess progress						Completed			

Support dissemination of the "Know the Five Signs" program through <a href="http://changedirection.org/NH">changedirection.org/NH</a>							Completed & Ongoing	Region 1 is working with Monadnock Family Services to offer a series of Mental Health Awareness trainings across the entire region - this has a focus on "Know the Five Signs" program.	Region 1 is working with Monadnock Family Services to offer a series of Mental Health Awareness trainings across the entire region - this has a focus on "Know the Five Signs" program. Ask Phil
Begin implementation of new self-management programs -									Move to delete this from Implementation Plan
Schedule Region-wide training sessions in cultural competency							Completed & Ongoing		
Schedule Region- wide training sessions in suicide prevention							Completed		Headrest did a suicide prevention training; forwarded NH Healthy Families two module training to all partners several times
Progress and expansion of Region 1 IDN Primary Care capacity to offer MAT							Completed & Ongoing	Medical Director is currently piloting program at the Multispecialty Clinic at Alice Peck Day Memorial Hospital and about to roll out to primary care practices across the region and state.	
Assess progress made across IDN 1 providers on SBIRT/MI Trainings							Completed & Ongoing	All of our partners have access to the CHI/JSI SBIRT MI Initiative but we will encourage further training in the next year. Additionally, Region 1 has an Intro to MI training on July 25th and then a two part training scheduled for September 25th and October 2nd.	Region 1 IDN continues to offer MI trainings and disseminate previously recorded trainings.
Support dissemination of the "Know the Five Signs" program through <a href="http://changedirection.org/NH">changedirection.org/NH</a>							Completed & Ongoing		
All Region 1 B1 providers have completed the SBIRT and MI training							Completed & Ongoing		All B1 providers have access to these trainings
All Region 1 B1 Providers Billing, Administration staff trained in MH and SUD							Completed & Ongoing		All B1 providers have access to these trainings
All IDN partner staff have had access to suicide prevention and cultural competency							Completed & Ongoing		

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

Deliverable/Milestone	Task Assignments		Ongoing
	Lead	Support	
<b>Implementation Year 1</b>			
Charter Completion- Final review and approval by all project team members	Molly O.	Jessica P.	
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month			
<b>Team Meetings</b>			
Set up recurring bi-weekly meetings at alternating site locations to support attendance across organizations	Molly O.	Jessica P.	
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	Jessica P.	Molly O.	
Support and document MDCT meetings monthly and case assessment process	Michelle L.	Tyler V.	
<b>Recruit to Hire - M1, 2</b>			
Document weekly progress toward position hiring and share with broader project team membership	Matt D.	Joanne W.	
Share job descriptions and links to postings with all project team members	Matt D.	Joanne W.	
Assign team member lead support for communication of progress and interview panel updates	Matt D.	Joanne W.	
<b>Onboarding</b>			
Formalize and document the onboarding and training process CTC	Matt D.	Joanne W.	
*Share with all project team members and address willingness to share with other programs			
Create a training plan by needed position to share and replicate for subsequent hires	All Pteam	Molly O. / Jessica P.	
*Address privacy and consent training for role within IDN SCP			
Address with project team onboarding activities to be supported by the IDN staff and partner network	All Pteam	Jessica P.	

<b>Training</b>			
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	All Pteam		
Train MDCT in roles and responsibilities	All Pteam		
Train MDCT in use of SCP and secure messaging	Mark B.		
Train community partners in use of SCP and secure messaging	Mark B.	All Pteam	
Train patients and families in use of SCP- IDN Supported	IDN Supported	All Pteam	
Determine physical health, mental health and SUD topics for MDCT training	All Pteam	Molly O.	
Decide on standardized, evidence-based training materials	IDN Supported		
Develop training schedule, including update schedule	Jessica P.	Pteam	
Train all staff in cultural sensitivity and destigmatization	IDN Supported		
Offer annual training to all project team membership on chronic disease management in the following domains:	IDN Supported		
Diabetes Hyperglycemia	IDN Supported		
Dyslipidimia	IDN Supported		
Hypertension	IDN Supported		
Mental Health Topics (Multiple)	IDN Supported		
SUD Topics (Multiple)	IDN Supported		
Offer basics of mental health first aid to practice billing and reception staff annually	IDN Supported		
* Address training funding capacity through current project funding, current systems to leverage and opportunities for alignment with the IDN1 workforce priority areas			
<b>Target Population-M2</b>			
Create a registry of Medicaid beneficiaries at D-H Heater Rd and West Central Behavioral Health	Tyler V. / Joanne W.	Nancy N.	
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems and current relationship with WCBH	Nancy N.	Cynthia T.	
Create a list of the patients who are seen most frequently for behavioral/mental health problems	Tyler V.	Joanne W.	
Create a sub-list of patients with documented SUDs, including substance(s)	Tyler V.	Joanne W.	
<b>Process Mapping and Patient Flows</b>			
Complete intake and screening process at WCBH	Nancy N.	Cynthia T.	
Finalize patient flow at both onboarding patient sites - WCBH, DH	Tyler V./Nancy N.	Molly O.	
Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision points	Molly O.		
<b>Process Milestones and Reporting</b>			
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM	Molly O.	Jessica P.	
Finalize operational dashboard for measures and measure collection	Jessica P.	Mark B.	
Present to larger project team for approval and finalization	Jessica P.	Molly O.	
Address IDN required data reporting and document reporting ownership with the project team. Identify lead and support for data and process reporting to the IDN	Jessica P.	Chelsea W.	

Continuously collect and interpret outcome data- <b>M3</b>	Data Lead Role		
Review pledged project outcomes with all partners	Data Lead Role		
Schedule quarterly project outcome review	Jessica P.		
Schedule quarterly report targets and deadlines	Jessica P.		
Analyze and review 6 months of project outcomes - <b>M4</b>	All Pteam		
Review and assess potential supplemental funding opportunities - <b>M4</b>	All Pteam		
*Focus on project sustainability			
<b><u>Comprehensive Core Standardized Assessment</u></b>			
Continue CCSA development and coordination with DH SDOH taskforce	Joanne W.	Chelsea W.	
Training across B1 teams on CCSA Implementation	All Pteam		
Crosswalk these domains with existing demographic, SDOH, and screening instruments currently in use	Molly O.	Jessica P.	
Integrate finalized CCSA into existing EMR	Mark B.	Jessica P.	
Integrate CCSA into workflow	All Pteam	Molly O.	
Address coordination with WCBH utilization of DLA20	Nancy N.	Molly O.	
Produce and finalize documentation with project team attesting to the tools in use across the project team and crosswalk to IDN determined domain areas	All Pteam	Molly O.	
<b><u>Comprehensive Core Standardized Assessment (Pediatric)</u></b>			
Determine the developmental screening instrument to be utilized with the CCSA			
Integrate developmental screening into existing EMR			
Integrate developmental screening into workflow			
<b><u>Shared Care Plan</u></b>			
Project team demo on SCP portal and needs	Mark B.	Jessica P.	
Address inclusion of non covered entities on SCP	Mark B.	Jessica P.	
* Look to Legal/Privacy for required consent, next steps and training			
<b><u>Budget</u></b>			
Establish use of funds tracking for pilot within current system - IDN	Jessica P.		
*Address unique DGR project code for salaries and expenditures			
Create funding matrix to show IDN funded areas and other supported positions, activities	Jessica P.		
Establish use of funds tracking and budget table	Jessica P.		
Share quarterly with IDN	All Pteam		

<b>Key Organizational and Provider Participants</b>			
Share formal award notice to all partners and supporting organizations	Joanne W.	Molly O.	
Document and continually support referral partnerships	Joanne W.	Molly O.	
Address any gap areas in partner support network- target through new partner cultivation	All Pteam	IDN	
Address cultural barriers and look to supported IDN trainings on culture change	All Pteam	IDN	
<b>Network Development - M2, M3</b>			
Project team review and identification of all formal project partners and community supports	All Pteam		
Assign team members to support development and outreach	Molly O.	Jessica P.	
Continue to expand and develop the network of collaborating organizations	All Pteam		
Review current process for developing new partner relationships	Molly O.	Jessica P.	
<b>Privacy &amp; Security</b>			
Train Staff on Treatment of Sensitive Patient Information			
Execute Data Sharing Arrangement with Support Services Organizations -M2	Data Lead Role		
*Identify areas where updates or new development is needed			
Linkage to IDN resources and forms	Jessica P.		
<b>HIT Implementation</b>			
Deploy Shared Care Plan Application	Mark B.	IDN Supported	
Deploy Direct Secure Messaging Application	Mark B.	IDN Supported	
Deploy Event Notification Application	Mark B.	IDN Supported	
Deploy Clinical Quality Measurement Application	Mark B.	IDN Supported	
HIT Components Completed and Functional - M2, M3	Mark B.	IDN Supported	
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup	Mark B.	IDN Supported	
<b>Integration Assessment</b>			
Complete SSA at 6, 12, 18 month intervals	Molly O.	Jessica P.	Ongoing
Projet team coordination for SSA completion, submission, and review	Molly O.	Jessica P.	
<b>Evaluation</b>			
Review for inclusion of evidence based practices determined in implementation plan	All Pteam		
At 6 month intervals (12/31/17, 6/30/18, 12/31/18) measure	Molly O.	Jessica P.	
# of external community support referrals from B1 team	Molly O.	Jessica P.	
Progress towards coordinated care practice designation	Molly O.	Jessica P.	

<b><u>Data Sharing</u></b>			
Outcome data accumulated and reviewed	Jessica P.	Molly O.	
Approve and disseminate data sharing forms to all project partners	All Pteam	Molly O.	
Share SSA Integration levels with B1 provider cohort	Jessica P.	All Pteam	
*Support IDN efforts for data transparency through reporting and project outcomes presentation			
<b><u>Meetings and Reports</u></b>			
Documented minimum requirement met quarterly	Reporting Lead	Jessica P.	
<b><u>Knowledge Exchanges and IDN Involvement</u></b>			
Share key learnings with IDN1 partners and participation quarterly	All Pteam	Jessica P.	
<b><u>Use of Funds</u></b>			
Appropriate use of project funds used monthly and actuals reported quarterly	Reporting Lead	Jessica P.	
<b><u>Accountability of Time</u></b>			
Accountability for use of staff time to serve project functions reported quarterly	Reporting Lead	Jessica P.	

## Appendix B1-2: VRH and CA

Deliverable/Milestone	Task Assignments		PRE-Q1	Q1	Q2	Q3	Q4	Status
	Lead	Support	11/17-12/17	1/1/18-3/30/18	4/1/18-6/30/18	7/1/18-9/30/18	10/1/18-12/31/18	
<b>IMPLEMENTATION YEAR ONE</b>								
Meeting with QI facilitator & IDN leadership and Counseling Associates to launch project	JP/AB/KM		✓					
Complete contracting process and submit	AB/JS	KM	✓					
Create MSW job description	AB/KM/TR		✓					
Begin advertising for RN in VPC (VRH funding)	AB	HR	✓	✓	✓			
Identify B1 work team members	AB/KM/TR		✓					
Identify ongoing work team meeting dates/time	AB/KM/TR		✓					
Meeting with VPC team for introduction of project	AB/KM/TR	JP/PM	✓					
Meet and Greet for VPC staff and providers with Counseling Associates staff	AB/KM/TR	JP/PM						
Identify Role for AmeriCorp member(s) and confirm	AB/KM/TR		N/A					
Charter Completion- Final review and approval by all project team members				✓				
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month				✓	✓			
<b>Team Meetings</b>								
Set up recurring bi-weekly meetings and support attendance across partner agencies				✓	✓			
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps				✓	✓			
Support and document MDCT meetings monthly and case assessment process								
<b>Recruit to Hire</b>								
Document weekly progress toward position hiring and share with broader project team membership					✓			
Share job descriptions and links to postings with all project team members								
Assign team member lead support for communication of progress and interview panel updates								

<b>Onboarding</b>								
Formalize and document the onboarding and training process for new positions					✓			
*Share with all project team members and address willingness to share with other programs								
Create a training plan by needed position to share and replicate for subsequent hires					✓			
*Address privacy and consent training for role within IDN SCP								
Address with project team onboarding activities to be supported by the IDN staff and partner network					✓			
<b>Training</b>								
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	All Pteam							
Train MDCT in roles and responsibilities	All Pteam							
Train MDCT in use of SCP and secure messaging	Mark B.							
Train community partners in use of SCP and secure messaging	Mark B.	All Pteam						
Train patients and families in use of SCP- IDN Supported	IDN Suppo	All Pteam						
Determine physical health, mental health and SUD topics for MDCT training	All Pteam							
Decide on standardized, evidence-based training materials	IDN Supported							
Develop training schedule, including update schedule	Jessica P.	Pteam						
Train all staff in cultural sensitivity and destigmatization	IDN Supported							
Offer annual training to all project team membership on chronic disease management in the following domains:	IDN Supported							
Diabetes Hyperglycemia	IDN Supported							
Dyslipidimia	IDN Supported							
Hypertension	IDN Supported							
Mental Health Topics (Mulitple)	IDN Supported							
SUD Topics (Multiple)	IDN Supported							
Offer basics of mental health first aid to practice billing and reception staff annually	IDN Supported							
* Address training funding capacity through current project funding, current systems to leverage and opportunities for alignment with the IDN1 workforce priority areas								

<b>Target Population-M2</b>								
Create a registry of Medicaid beneficiaries at VRH Primary Care and Counseling Associates					underway			
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems and current relationship with WCBH								
Create a list of the patients who are seen most frequently for behavioral/mental health problems								
Create a sub-list of patients with documented SUDs, including substance(s)								
<b>Process Mapping and Patient Flows</b>								
Complete intake and screening process at VRH, CA					underway			
Finalize patient flow at both onboarding patient sites - VRH, CA					underway			
Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision points								
<b>Process Milestones and Reporting</b>								
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM								
Finalize operational dashboard for measures and measure collection	Jessica P.	Mark B.						
Present to larger project team for approval and finalization	Jessica P.							
Address IDN required data reporting and document reporting ownership with the project team. Identify lead and support for data and process reporting to the IDN	Jessica P.							
Continuously collect and interpret outcome data	Data Lead Role							
Review pledged project outcomes with all partners	Data Lead Role							
Schedule quarterly project outcome review	Jessica P.							
Schedule quarterly report targets and deadlines	Jessica P.							
Analyze and review 6 months of project outcomes	All Pteam							
Review and assess potential supplemental funding opportunities	All Pteam							
*Focus on project sustainability								
<b>Comprehensive Core Standardized Assessment</b>								
Training across B1 teams on CCSA Implementation					✓			
Crosswalk these domains with existing demographic, SDOH, and screening instruments currently in use					✓			
Integrate finalized CCSA into existing EMR					underway			
Integrate CCSA into workflow					underway			
Produce and finalize documentation with project team attesting to the tools in use across the project team and crosswalk to IDN determined domain areas								
<b>Comprehensive Core Standardized Assessment (Pediatric)</b>								
Determine the developmental screening instrument to be utilized with the CCSA								
Integrate developmental screening into existing EMR								

Integrate developmental screening into workflow								
<b>Shared Care Plan</b>								
Project team demo on SCP portal and needs	Mark B.	Jessica P.						
Address inclusion of non covered entities on SCP	Mark B.	Jessica P.						
* Look to Legal/Privacy for required consent, next steps and training								
<b>Budget</b>								
Establish use of funds tracking for pilot within current system - IDN	Jessica P.			✓	✓			
*Address unique DGR project code for salaries and expenditures								
Create funding matrix to show IDN funded areas and other supported positions, activities	Jessica P.							
Establish use of funds tracking and budget table	Jessica P.			✓	✓			
Share quarterly with IDN	All Pteam							
<b>Key Organizational and Provider Participants</b>								
Share formal award notice to all partners and supporting organizations								
Document and continually support referral partnerships								
Address any gap areas in partner support network- target through new partner cultivation	All Pteam	IDN						
Address cultural barriers and look to supported IDN trainings on culture change	All Pteam	IDN						
<b>Network Development</b>								
Project team review and identification of all formal project partners and community supports	All Pteam							
Assign team members to support development and outreach								
Continue to expand and develop the network of collaborating organizations	All Pteam							
Review current process for developing new partner relationships								
<b>Privacy &amp; Security</b>								
Train Staff on Treatment of Sensitive Patient Information								
Execute Data Sharing Arrangement with Support Services Organizations	Data Lead Role							
*Identify areas where updates or new development is needed								
Linkage to IDN resources and forms	Jessica P.							
<b>HIT Implementation</b>								
Deploy Shared Care Plan Application	Mark B.	IDN Supported						
Deploy Direct Secure Messaging Application	Mark B.	IDN Supported						
Deploy Event Notification Application	Mark B.	IDN Supported						
Deploy Clinical Quality Measurement Application	Mark B.	IDN Supported						
HIT Components Completed and Functional	Mark B.	IDN Supported						
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup	Mark B.	IDN Supported						
<b>Integration Assessment</b>								

<b>Integration Assessment</b>								
Complete SSA at 6, 12, 18 month intervals	Molly O.	Jessica P.						
Projet team coordination for SSA completion, submission, and review	Molly O.	Jessica P.						
<b>Evaluation</b>								
Review for inclusion of evidence based practices determined in implementation plan								
At 6 month intervals (12/31/17, 6/30/18, 12/31/18) measure								
# of external community support referrals from B1 team								
Progress towards coordinated care practice designation								
<b>Data Sharing</b>								
Outcome data accumulated and reviewed								
Approve and disseminate data sharing forms to all project partners								
Share SSA Integration levels with B1 provider cohort								
*Support IDN efforts for data transparency through reporting and project outcomes presentation								
<b>Meetings and Reports</b>								
Documented minimum requirement met quarterly	Reporting	Jessica P.						
<b>Knowledge Exchanges and IDN Involvement</b>								
Share key learnings with IDN1 partners and participation quarterly	All Pteam	Jessica P.						
<b>Use of Funds</b>								
Appropriate use of project funds used monthly and actuals reported quarterly	Reporting	Jessica P.						
<b>Accountability of Time</b>								
Accountability for use of staff time to serve project functions reported quarterly	Reporting	Jessica P.						
<b>Project Defined Milestones</b>								
<b>Milestone: Q1</b>								
Develop work group for project implementation								
<b>Milestone: Q2</b>								
Hire for position(s)								
<b>Milestone: Q2, Q3</b>								
Adapt clinic work flow and processes for implementation								
<b>Milestone: Q2</b>								
Develop Partnership Agreement with counseling service provider								
<b>Milestone: Q2, Q3</b>								
Develop Standardized Workflows and Protocols								
<b>Milestone: Q2, Q3</b>								
Create protocols to ensure safe care transitions from institutional settings								
<b>Milestone: Q3</b>								
Implement Shared Care Plan								

<b>Milestone: Q3</b>									
Implement Standardized Workflows and Protocols									
<b>Milestone: Q4</b>									
Implement process for follow up after ED visit or hospitalization									
<b>Milestone: Q4</b>									
Screening implemented across PCP office									
<b>Milestone: Q4</b>									
Implement protocols to ensure safe care transitions from institutional settings									
<b>Milestone: Q4</b>									
Comprehensive and consistent use of standardized core assessment framework									

## Appendix B1-2: CMC/MFS

Deliverable/Milestone	Task Assignments		Q1	Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
	Lead	Support	Present - 9/30/18	10/1/18-12/31/18	1/1/19-3/30/19	4/1/19-6/30/19				
<b>Implementation Year 1</b>										
Charter Completion- Final review and approval by all project team members	Dee W.	Jessica P.						August, 2018	September, 2018	Complete
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month										
<b>Team Meetings</b>										
Set up recurring bi-weekly meetings at alternating site locations to support attendance across organizations	Dee W.	Jessica P.								Complete
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	Dee W.	Jessica P.						August, 2018	September, 2018	Complete
Support and document MDCT meetings monthly and case assessment process	Project Team to Identify							*Pending Formal Clinical Launch		
<b>Recruit to Hire - M1, 2</b>										
Document weekly progress toward position hiring and share with broader project team membership	Project Team to Identify							August, 2018	September, 2018	Complete
Share job descriptions and links to postings with all project team members	Project Team to Identify							August, 2018	September, 2018	Complete
Assign team member lead support for communication of progress and interview panel updates	Project Team to Identify								September, 2018	Complete
<b>Onboarding</b>										
Formalize and document the onboarding and training process for NP	Project Team to Identify							September, 2018	February, 2018	In Process
*Share with all project team members and address willingness to share with other programs										
Create a training plan by needed position to share and replicate for subsequent hires	All Pteam	Dee W. / Jessica P.						*Pending Initial Hire and Project Rollout		
*Address privacy and consent training for role within IDN SCP										
Address with project team onboarding activities to be supported by the IDN staff and partner network	All Pteam	Jessica P.						September, 2018		Complete
<b>Training</b>										
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	All Pteam	Dee W. / Jessica P.								
Train MDCT in roles and responsibilities	All Pteam	Dee W. / Jessica P.								
Train MDCT in use of SCP and secure messaging		Mark B./Jaime D.								
Train community partners in use of SCP and secure messaging		All Pteam						September, 2018	October, 2018	
Train patients and families in use of SCP- IDN Supported	IDN Supported	All Pteam						September, 2018	October, 2018	
Determine physical health, mental health and SUD topics for MDCT training	All Pteam	Dee W./Jan T.						September, 2018	February, 2019	
Decide on standardized, evidence-based training materials	IDN Supported							September, 2018	February, 2019	

Develop training schedule, including update schedule	Jessica P.	Pteam						August, 2018	January, 2019	
Train all staff in cultural sensitivity and destigmatization	IDN Supported							September, 2018	February, 2019	
Offer annual training to all project team membership on chronic disease management in the following domains:	IDN Supported									
Diabetes Hyperglycemia	IDN Supported									
Dyslipidemia	IDN Supported									
Hypertension	IDN Supported									
Mental Health Topics (Multiple)	IDN Supported									
SUD Topics (Multiple)	IDN Supported									
Offer basics of mental health first aid to practice billing and reception staff annually	IDN Supported							Available on IDN1 Website	December, 2018	
* Address training funding capacity through current project funding, current systems to leverage and opportunities for alignment with the IDN1 workforce priority areas										
<b>Target Population-M2</b>										
Create a registry of Medicaid beneficiaries at Chesire Medical Center and Monadnock Family Services	All Pteam	Dee W. / Jessica P.						October, 2018	March, 2019	
Create a registry of Medicaid beneficiaries with documented behavioral/mental health problems and current relationship with MFS	All Pteam	Dee W. / Jessica P.						October, 2018	March, 2019	
Create a list of the patients who are seen most frequently for behavioral/mental health problems	All Pteam	Dee W. / Jessica P.						October, 2018	March, 2019	
Create a sub-list of patients with documented SUDs, including substance(s)	All Pteam	Dee W. / Jessica P.						October, 2018	March, 2019	
<b>Process Mapping and Patient Flows</b>										
Complete intake and screening process at MFS	Dee W.	Jessica P.						September, 2018	February, 2019	In Process
Finalize patient flow at both onboarding patient sites - MFS, CMC	Dee W.	Jessica P.						September, 2018	February, 2019	In Process
Address other mapping with teams- communication flows through SCP, role of CTC within MDCT and connector/decision points	Dee W.	Jessica P.						September, 2018	February, 2019	In Process
<b>Process Milestones and Reporting</b>										
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM	Dee W.	Jessica P.						September, 2018	January, 2019	
Finalize operational dashboard for measures and measure collection	Jessica P.							September, 2018	October, 2018	
Present to larger project team for approval and finalization	Jessica P.	Dee W.						October, 2018	October, 2018	
Address IDN required data reporting and document reporting ownership with the project team. Identify lead and support for data and process reporting to the IDN	Jessica P.							September, 2018	October, 2018	

<b>Continuously collect and interpret outcome data- M3</b>	Data Lead Role									
Review pledged project outcomes with all partners	Data Lead Role							Ongoing		
Schedule quarterly project outcome review	Jessica P.							Ongoing		
Schedule quarterly report targets and deadlines	Jessica P.							Ongoing		
<b>Analyze and review 6 months of project outcomes -M4</b>	All Pteam									
<b>Review and assess potential supplemental funding opportunities -M4</b>	All Pteam									
*Focus on project sustainability										
<b>Comprehensive Core Standardized Assessment</b>										
Continue CCSA development and coordination with IDN1 CCSA Protocol	All Pteam	Dee W./Jessica P.						Ongoing	Ongoing	
Integrate finalized CCSA into existing EMR	All Pteam	Jessica P.						September, 2018	November, 2018	
Integrate CCSA into workflow	All Pteam	Dee W.						September, 2018	November, 2018	
Address coordination with MFS utilization of DLA20	All Pteam	Dee W.						September, 2018	November, 2018	
Produce and finalize documentation with project team attesting to the tools in use across the project team and crosswalk to IDN determined domain areas	All Pteam	Dee W.						September, 2018	November, 2018	
<b>Comprehensive Core Standardized Assessment (Pediatric)</b>										
Determine the developmental screening instrument to be utilized with the CCSA										
Integrate developmental screening into existing EMR										
Integrate developmental screening into workflow										
* Pending Launch with Pediatrics										
<b>Shared Care Plan</b>										
Project team demo on SCP portal and needs	Mark B./Jaime D.	Jessica P.						September, 2018	September, 2018	
Address inclusion of non covered entities on SCP	Mark B./Jaime D.	Jessica P.						September, 2018	September, 2018	
<b>Budget</b>										
Share quarterly with IDN	All Pteam							Ongoing	Ongoing	
<b>Key Organizational and Provider Participants</b>										
Share formal award notice to all partners and supporting organizations	All Pteam	Dee W.								Complete
Document and continually support referral partnerships		Dee W.						Ongoing	Ongoing	
Address any gap areas in partner support network- target through new partner cultivation	All Pteam	IDN						Ongoing	Ongoing	
Address cultural barriers and look to supported IDN trainings on culture change	All Pteam	IDN						Ongoing	Ongoing	
<b>Network Development - M2, M3</b>										
Assign team members to support development and outreach	Dee W.	Jessica P.						Ongoing	Ongoing	
Continue to expand and develop the network of collaborating organizations	All Pteam							Ongoing	Ongoing	

Review current process for developing new partner relationships	Dee W.	Jessica P.						Ongoing	Ongoing	
<b>Privacy &amp; Security</b>										
Execute Data Sharing Arrangement with Support Services Organizations -M2	Data Lead Role									
*Identify areas where updates or new development is needed										
<b>HIT Implementation</b>										
Deploy Shared Care Plan Application	CMC/MFS IT	IDN Supported							December, 2018	
Deploy Direct Secure Messaging Application	CMC/MFS IT	IDN Supported							December, 2018	Complete
Deploy Event Notification Application	CMC/MFS IT	IDN Supported							December, 2018	Complete
Deploy Clinical Quality Measurement Application	CMC/MFS IT	IDN Supported							December, 2018	
HIT Components Completed and Functional - M2, M3		IDN Supported								
<b>Integration Assessment</b>										
Complete SSA at 6, 12, 18 month intervals	Dee W.	Jessica P.						Ongoing	Ongoing	
Project team coordination for SSA completion, submission, and review	Dee W.	Jessica P.						Ongoing	Ongoing	
<b>Evaluation</b>										
At 6 month intervals measure	Dee W.	Jessica P.						Ongoing	Ongoing	
# of external community support referrals from B1 team	Dee W.	Jessica P.						Ongoing	Ongoing	
Progress towards coordinated care practice designation	Dee W.	Jessica P.						Ongoing	Ongoing	
<b>Data Sharing</b>										
Outcome data accumulated and reviewed	Jessica P.	Dee W.						Ongoing	Ongoing	
Share SSA Integration levels with B1 provider cohort	Jessica P.	All Pteam						Ongoing	Ongoing	
*Support IDN efforts for data transparency through reporting and project outcomes presentation										
<b>Meetings and Reports</b>										
Documented minimum requirement met quarterly	Reporting Lead	Jessica P.						Ongoing	Ongoing	
<b>Knowledge Exchanges and IDN Involvement</b>										
Share key learnings with IDN1 partners and participation quarterly	All Pteam	Jessica P.						Ongoing	Ongoing	
<b>Use of Funds</b>										
Appropriate use of project funds used monthly and actuals reported quarterly	Reporting Lead	Jessica P.						Ongoing	Ongoing	
<b>Accountability of Time</b>										
Accountability for use of staff time to serve project functions reported quarterly	Reporting Lead	Jessica P.						Ongoing	Ongoing	

## Appendix B1-2: APD

Deliverable/Milestone	Task Assignments		PRE-Q1	Q1			Q1	Q2	Q3	Q4	Status
	Lead	Support	10/17-12/18	Jan, 2019	Feb, 2019	Mar, 2019	1/1/19-3/30/19	4/1/19-6/30/19	7/1/19-9/30/19	10/1/19-12/31/19	
<b>IMPLEMENTATION YEAR ONE</b>											
Meeting with QI facilitator & IDN leadership to launch project	Jessica P.	Stephanie C.									Complete
Complete contracting process and submit	Brian L.	Jessica P.									Complete
Create Psychiatry job description	Colin S.	Brian L.									Underway
Identify B1 work team members	Brian L.	Lauren S.									Complete
Identify ongoing work team meeting dates/time	Sarah L.	Stephanie C.									Complete
Meeting with APD team for introduction of project	Jessica P.	Stephanie C.									Complete
Charter Completion- Final review and approval by all project team members	Pending										
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month											
<b>Team Meetings</b>											
Set up recurring bi-weekly meetings and support attendance across partner agencies	Sarah L.	Stephanie C.									Complete
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	Stephanie	Sarah L.									
Set up recurring MDCT meetings monthly and case assessment process	Sarah L.	Stephanie C.									
<b>Recruit to Hire</b>											
Document weekly progress toward position hiring and share with broader project team membership	Colin S.										
Share job descriptions and links to postings with all project team members	Colin S.										
Assign team member lead support for communication of progress and interview panel updates	Colin S.										
<b>Onboarding</b>											
Formalize and document the onboarding and training process for new positions	Colin S.	Brian L.									
Create a training plan by needed position to share and replicate for subsequent hires	Colin S.	Brian L.									
Address with project team onboarding activities to be supported by the IDN staff and partner network	Jessica P.										
<b>Training</b>											
Train flow and clinical staff in administration and use of CCSA, assigning responsibilities	All Pteam										
Train MDCT in roles and responsibilities	All Pteam										
Train MDCT in use of SCP and secure messaging	Jaime D.										
Train community partners in use of SCP and secure messaging	Jaime D.	All Pteam									
Train patients and families in use of SCP- IDN Supported	IDN Support	All Pteam									
Determine physical health, mental health and SUD topics for MDCT training	All Pteam										
Decide on standardized, evidence-based training materials	IDN Supported										



Review and assess potential supplemental funding opportunities	All Pteam											
*Focus on project sustainability												
<b>Comprehensive Core Standardized Assessment</b>												
Training across B1 teams on CCSA Implementation												
Crosswalk these domains with existing demographic, SDOH, and screening instruments currently in use												
Integrate finalized CCSA into existing EMR												
Integrate CCSA into workflow												
Produce and finalize documentation with project team attesting to the tools in use across the project team and crosswalk to IDN determined domain areas												
<b>Comprehensive Core Standardized Assessment (Pediatric)</b>												
Determine the developmental screening instrument to be utilized with the CCSA												
Integrate developmental screening into existing EMR												
Integrate developmental screening into workflow												
<b>Shared Care Plan</b>												
Project team demo on SCP portal and needs	Jaime D.	Jessica P.										
Address inclusion of non covered entities on SCP	Jaime D.	Jessica P.										
<b>Budget</b>												
Establish use of funds tracking for pilot within current system - IDN	Jessica P.											
Share quarterly with IDN	All Pteam											
<b>Key Organizational and Provider Participants</b>												
Share formal award notice to all partners and supporting organizations												
Document and continually support referral partnerships												
Address any gap areas in partner support network- target through new partner cultivation	All Pteam	IDN										
Address cultural barriers and look to supported IDN trainings on culture change	All Pteam	IDN										
<b>Network Development</b>												
Project team review and identification of all formal project partners and community supports	All Pteam											
Assign team members to support development and outreach												
Continue to expand and develop the network of collaborating organizations	All Pteam											
Review current process for developing new partner relationships												
<b>Privacy &amp; Security</b>												
Train Staff on Treatment of Sensitive Patient Information												
Execute Data Sharing Arrangement with Support Services Organizations	Data Lead Role											



## Appendix B1-2: NHC

Deliverables	Responsible	Support	Date Due	Progress
<b>Dec-18</b>				
Finalize CCSA (SDoH, BH)	NHC Project Team		12/21/2018	
- Draft BH assessment	Stephanie	Jessica	12/14/2018	Complete
- Final Draft SDoH	Stephanie	Jessica	12/14/2018	Complete
Finalize letter to guardians regarding CCSA and MDCT	Erin		12/14/2018	
Draft MDCT/SCP plan processes and protocols			12/21/2018	
- Send examples to NHC	Stephanie		12/4/2018	Complete
- Review and comment/update for NHC	Erin	NHC team	12/14/2018	
Determine apt type to implement CCSA (process)	NHC team		12/14/2018	
- Process for determining which pt receives CCSA	NHC team		12/14/2018	
Finalize registry tool	Stephanie		12/14/2018	
Draft CHW Onboarding check list	Erin	Leslie	12/14/2018	
- Ask HR for NLH requirements	Erin	Leslie	12/14/2018	
- Ask DHMC for recommendations	Erin		12/14/2018	
- Trainings for CHW	Jessica		12/14/2018	
Pathways for CCSA positives	Erin		12/14/2018	
- Send examples to Erin	Stephanie	Jessica	12/4/2018	Complete
Create list for possible MDCT regular mtgs	Erin		12/14/2018	
<b>Jan-19</b>				
Prepare and Train for CCSA implementation	NHC Team	Stephanie	1/11/2018	
Go live with CCSA, Future State Work Flow, Pathways, Registry	NHC Team	Stephanie	1/14/2018	
Finalize Consent and Process	NHC Team	Stephanie	1/25/2018	

Finalize MDCT/SCP Protocols and Progress	NHC Team	Stephanie	1/11/2018	
Finalize Algorithm for pts elevated to MDCT	NHC Team	Stephanie	1/11/2018	
Meet with WCBH and CA to discuss relationship, prepare for MDCT	NHC Team	Erin	12/21/2018	
<b>Feb-19</b>				
Go live with MDCT and Shared Care Plan	NHC Team	Stephanie	TBD	

## Appendix C-1

Deliverable/Milestone	Task Assignments		Ongoing
<b>Implementation Year 1/2</b>	Lead	Support	
<b>Recruit to Hire Coordinator Staff - M1, 2</b>			
Finalize job description- Review by all team members and facilitators			
Address hiring process with MFS, MC			
*Outline timeline for internal hiring processes and projected date to hire			
Assign team support for job posting, resume review, and interview scheduling			
Identify interview panel members			
*Address tie-ins to workforce loan repayment planning			
Formalize E5 Coordinator Training plan (onboarding process and length)			
*Include PHI Privacy and 42 CFR Pt. II needs			
Revise timeline process for date of hire to direct patient support			
<b>Project Team Development- M2</b>			
Email to all partners notifying of project award			
Schedule and plan for all-partner meeting			
Review partner roles : any need for additional support on project team	Phil	Kate C	
Review community service organization partners and address any gaps	Phil	Maryanne	
*Opportunity to address current referral and assessment gaps, high functioning processes, and technology capacity of partner entities			
Schedule recurring parter meetings (quarterly or semi-annual)			
Environmental scan for overlap with other Cheshire County projects, networks and coordinated meetings			
* IDN requirements will be met with leveraging existing structures			
<b>Patient Identification and Screening - M2</b>			
Identify priority data fields for screening	Phil / Team	Mark B	
Coordinate with B1 Planning Team at CMC (E5 Overlap)	Phil	Maryanne	

Support IT and IDN HIT meeting for review of process steps and registry identification	Phil / Team	Kate	
Define target pilot caseload (size and acuity) for E5 Coordinators			
Outline patient and reporting data collection needs - <b>M2</b>			
*Highlight current fields being met and new areas			
Develop rolling identification process for new client identification- <b>M2, 3</b>			
*Formalize and share with partners- support with referral process			
Target project team subgroup to address data and reporting			
Coordinate with HIT B1 implementation			
Address Shared Care Plan usage			
*Leverage adoption and training support from other initiatives			
<b>Screening and Assessment Tool Development -M2</b>			
Review of current tools across partner network			
Review of CTI case management toolkit			
Map end-to-end processes for CTI tailored to Cheshire sub-region			
Identify patient assessment protocols and tools			
Identify patient management protocols			
Identify referral process and tools			
Referral and Assessment process development- <b>M2</b>			
<b>Outcomes Measurement - M</b>			
Review pledged project outcomes with all partners			
Schedule quarterly project outcome review			
Schedule quarterly report targets and deadlines			
Analyze and review 6 months of project outcomes - <b>M4</b>			
Review and assess potential supplemental funding opportunities - <b>M4</b>			
*Focus on project sustainability			
Identify measures, targets for ongoing evaluation			
Develop tollgates to ensure adherence to CTI model for Phase I, II, III			
Formalize Internal Project Evaluation Process - <b>M2</b>			
Quarterly Performance Metrics Review by Oversight Team-Recurring - <b>M</b>			

Implement Measurements Project Dashboard - <b>M3</b>			
<b>Training-M</b>			
CTC participation in November 2017 CTI Training			
CTC Supervisor participation in November and December CTI Training			
Participation in Summer 2018, CTI Train the Trainer sessions			
Develop and formalize E5 Coordinator training			
* Share with other project teams			
<b>Legal and Privacy</b>			
Assess current MFS, MC processes and forms			
Coordinate with B1 Planning Team at CMC (MFS Pilot)			
Linkage to IDN resources and forms			
Execute data sharing agreements with partners, MOUs - <b>M</b>			
<b>Budget</b>			
Establish use of funds tracking and budget table			
Share quarterly with IDN			
<b>Network Development</b>			
Continue to expand and develop the network of collaborating organizations			
Identify Participating Support Services Organizations			
Formalize Relationship with Support Services Organizations			
Build Awareness of new Resources Among Hospital Key Personnel			
CTI CTC's participation in Monthly Community of Practice meetings - <b>M</b>			
<b>HIT Implementation- M2, 3</b>			
Deploy Shared Care Plan Application			
Deploy Direct Secure Messaging Application			
Deploy Event Notification Application			
Deploy Clinical Quality Measurement Application			
Utilize technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup			
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup			
<b>Meetings and Reports</b>			

Documented minimum requirement met quarterly			
<b><i>Knowledge Exchanges and IDN Involvement</i></b>			
Share key learnings with IDN1 partners and participation quarterly			
<b><i>Use of Funds</i></b>			
Appropriate use of project funds used monthly and actuals reported quarterly			
<b><i>Accountability of Time</i></b>			
Accountability for use of staff time to serve project functions reported quarterly			

## Appendix D-1

Deliverable/Milestone	Ongoing
<b>Implementation Year 1</b>	
Charter Completion- Final review and approval by all project team members	
*All identified team members will be expected to attend at least 1 of the biweekly team meetings per month	
<b>Team Meetings</b>	
Set up recurring bi-weekly meetings to be attended by all applicable project team members at each meeting	
Develop and approve a formal meeting communication form to communicate identified action items and follow up steps	
<b>Recruit to Hire - M1, 2</b>	
Document weekly progress toward position hiring and share with broader project team membership	
Share job descriptions and links to postings with all project team members	
Assign team member lead support for communication of progress and interview panel updates	
<b>Onboarding and Training</b>	
Formalize and document the onboarding and training process for each new role	
*Share with all project team members and address willingness to share with other programs	
Create a training plan by needed position to share and replicate for subsequent hires	
*Address privacy and consent training for role within IDN SCP	
Creation of staffing schedule	
<b>Process Milestones and Reporting</b>	
Review all proposed project milestones and objectives with key members of the project team, QI support, and IDN PM	
Finalize operational dashboard for measures and measure collection	
Present to larger project team for approval and finalization	
Address IDN required data reporting and document reporting ownership with the project team. Identify lead and support for data and process reporting to the IDN	
Continuously collect and interpret outcome data- <b>M3</b>	

<b><u>Outcomes Measurement</u></b>	
Review pledged project outcomes with all partners	
Schedule quarterly project outcome review	
Schedule quarterly report targets and deadlines	
Analyze and review 6 months of project outcomes - <b>M4</b>	
Review and assess potential supplemental funding opportunities - <b>M4</b>	
*Focus on project sustainability	
<b><u>Training</u></b>	
Develop and offer CBT training for applicable project staff	
Develop and offer DBT training for applicable project staff	
Develop and offer Motivational Interviewing/Enhancement training for applicable project staff	
Develop and offer Relapse prevention for applicable project staff	
Offer Circle of Security training for IOP staff	
Determine prioritized training guide and align with project timeline (address topics above and below)	
Offer Specific Trainings to Staff	
Prenatal care	
SUD-specific prenatal education:	
Risks of substance exposure, inclusive of tobacco/marijuana	
Managing pregnancy-associated side effects of MAT (primarily nausea and constipation)	
Optimizing nutrition during pregnancy and breastfeeding	
Neonatal abstinence syndrome: diagnosis, management, aftercare	
Pregnancy, HCV and/or HIV testing	
Breastfeeding and MAT	
Hospital drug testing policies	

Mandated reporting and the Plan of Safe Care	
<i>Not pregnancy-focused</i>	
Screening and treatment for sexually transmitted disease, including partner treatment	
Safe sex counseling, including condom distribution	
Cervical cancer screening	
Hepatitis and HIV education, screening, and referral	
Pregnancy testing, options counselling, and access to abortion care (referrals)	
Tuberculosis testing	
Counselling for pregnancy intention	
Influenza vaccination	
Domestic violence screening	
Tobacco use counselling and treatment	
Reproductive health education	
Curriculum development for pregnant and parenting women	
Case management training	
Psychiatric Assessment - Protocol development	
MAT development	
* Address training funding capacity through current project funding, current systems to leverage and opportunities for alignment with the IDN1 workforce priority areas	

<b>Assessment and Materials Developed</b>	
Document intake protocols	
Document participation guidelines	
Develop family support childcare guidelines	
IOP Initial curriculum development - <b>M2</b>	
Formalize with project team support and roll up into program operations bundle	
Implement 6 month tollgates for materials review (curriculum, protocols etc.) - <b>M3</b>	
Finalized Curriculum- <b>M4</b>	
<b>Budget</b>	
Establish use of funds tracking for pilot and within current system	
*Address unique DGR project code for salaries and expenditures	
Create funding matrix to show IDN funded areas and other supported positions, activities	
Ongoing review of sustainable funding sources- <b>M4</b>	
Establish use of funds tracking and budget table	
Share quarterly with IDN	
<b>Key Organizational and Provider Participants</b>	
Share formal award notice to all partners and supporting organizations	
Document and continually support referral partnerships	
Address any gap areas in partner support network- target through new partner cultivation	
Patient Advisory Board- Determine meeting frequency, membership- <b>M2</b>	
<b>Network Development - M2, M3</b>	
Develop outreach and program marketing campaign	
Assign team members to support development and outreach	
Continue to expand and develop the network of collaborating organizations	
Review current process for developing new partner relationships and	
<b>Assessment and Screening Tools</b>	
Develop with Project Team Scope of Work assessment and screening minimum requirements	

Utilize a comprehensive core assessment and a care plan for each enrolled patient, updating regularly	
Coordinate with the B1 projects for SCP and CCSA Analysis	
Determine screening used for client triage and caseload assignment	
Institute continuous improvement and review of the referral process functionality	
Set up Referral to Recovery Supports process	
Set up Referral to Counseling process	
Set up Inbound Referral process	
<b>Privacy &amp; Security</b>	
Train Staff on Treatment of Sensitive Patient Information	
Execute Data Sharing Arrangement with Support Services Organizations -M2	
Review current PATP consent and privacy forms	
*Identify areas where updates or new development is needed	
Assess current VRH processes and forms	
Coordinate with B1 Planning Team at VRH	
Linkage to IDN resources and forms	
Execute data sharing agreements with partners -M	
<b>HIT Implementation</b>	
Deploy Shared Care Plan Application	
Deploy Direct Secure Messaging Application	
Deploy Event Notification Application	
Deploy Clinical Quality Measurement Application	
HIT Components Completed and Functional - M2, M3	
Utilize technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup	
Utilize the IDN supported technology based systems to track and share care plans- Coordinate with Statewide HIT taskforce and Region 1 IT/Data Workgroup	
<b>Launch Services- M2, M3</b>	
Create timeline for program expansion rollout from Monday to Thursday clinical implementation	
Identify population of Medicaid-eligible women with substance use disorders who meet criteria for ASAM level 2.7 services	
Implement evidence-based, trauma-focused curriculum	

Implement co-location model	
Provide Comprehensive Screening/Intake Assessment	
Provide Care Planning including addressing all ASAM domains, medical, and psychiatric needs	
Operate 8-week IOP Treatment Model to include the following:	
Provide Referrals to Counseling	
Provide Referrals to Peer Supports/Recovery Coaches	
Provide Referral to Smoking Cessation Support	
Receive Inbound Referrals	
Provide Life Skills Programming	
Provide Urine drug screens and breathalyzer testing	
Provide continuing services post 8-week IOP	
<b>Expand Childcare Model- M2, 3</b>	
Expand current childcare model	
Provide childcare during group sessions	
Address formalizing priority criteria for supporting participants with childcare	
<b>Business Case</b>	
Develop initial Business Case for Scaling the IOP model	
Test and Refine Business Case for Scaling the IOP model	
<b>Evaluation</b>	
Establish 2018/2019 program objectives -M4	
<b>Data Sharing</b>	
Address data sharing with PATP, IDN	
Outcome data accumulated and reviewed	
Approve and disseminate data sharing forms to all project partners	
Support IDN efforts for data transparency through reporting and project outcomes presentation	
<b>Meetings and Reports</b>	
Documented minimum requirement met quarterly	
<b>Knowledge Exchanges and IDN Involvement</b>	
Share key learnings with IDN1 partners and participation quarterly	
<b>Use of Funds</b>	

## Appendix E-1

Please note given the early stage of project restructuring this work plan is still in draft format and may be updated

Deliverable/Milestone	Task Assignments		Q2	Q3	Q4	Ongoing	Target Start	Target Completion	Status
	Lead	Support	10/1/17-12/31/17	1/1/18-3/30/18	4/1/18-6/30/18				
<b>Implementation Year 1</b>									
<b>Contract Approval</b>									
Address VRH or IDN barriers to contract approval and release									
*Target subcontract payment by 10/31/17									
<b>Recruit to Hire Coordinator Staff - M1, 2</b>									
Finalize job description- Review by all team members and facilitators									
*Outline timeline for internal hiring processes and projected date to hire									
Assign team support for job posting, resume review, and interview scheduling									
Interview potential hires									
Confirm hiring choice and secure payment delivery method / contracting									
<b>Outreach to Project Partners - M1, 2</b>									
Email to all partners notifying of project award									
Draft of emails reviewed by Jessica Powell, Ashley Greenfield, and facilitators									
Schedule time at Community Partners Meeting in Newport and Claremont									
Review roles of referral and assessment categories									
Review community service organization partners and address any gaps									
Schedule recurring parter meetings to occur during monthly Community Partners Meetings									
Maintain coordination with Public Health Network and Continuum of Care - M2									
Environmental scan for overlap with other Sullivan County projects, networks and coordinated meetings									
* IDN requirements will be met with leveraging existing structures									
Initiate coordinated referral partnership agreement with partners - M2									
<b>Identification of Patient Registry - M2</b>									

Identify priority data fields for screening										In progress - cases being piloted for discussion. Referral form drafted.
Define target pilot caseload (size and acuity)										group determined 1 - cases per meeting to be discussed, dependant on need
Outline patient and reporting data collection needs - M2										
*Highlight current fields being met and new areas										
Develop rolling identification process for new client identification										
*Formalize and share with partners- support with referral process										
Target project team subgroup to address data and reporting										
Coordinate with HIT B1 implementation										
Address Shared Care Plan usage with E5 team										
*Leverage adoption and training support from other initiatives										
<b>Screening and Barriers Tool Development -M2</b>										
Review of current tools across partner network										
Identify a tool development timeline for workgroup	JP	Kcox							Ongoing	Will be developed after referral form and criteria are landed
Review and adopt screening barriers assessment with partner agencies- M2									Ongoing	
Referral and Assessment process development- M2									Ongoing	
Partner approval and adoption									Ongoing	
Support training for all referral sources- M2										
Schedule partner referral process review at 3-6 months utilization -M2,3										
<b>Outcomes Measurement</b>										
Review pledged project outcomes with all partners										
Schedule quarterly project outcome review										
Schedule quarterly report targets and deadlines										
Analyze and review 6 months of project outcomes -M4										
Review and assess potential supplemental funding opportunities - M4										
*Focus on project sustainability										
<b>Legal and Privacy</b>										
Coordinate with B1 Planning Team at VRH										
Linkage to IDN resources and forms										

