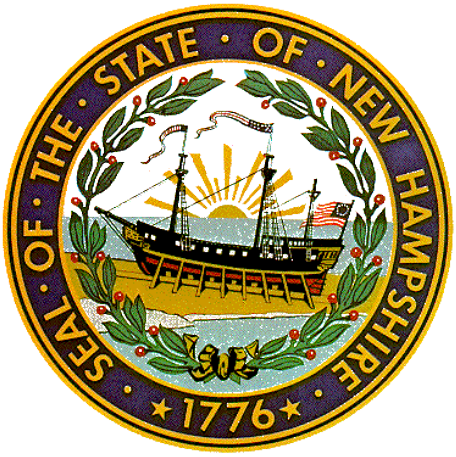

New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN 3 SEMI-ANNUAL REPORT (SAR)

January to June 2019

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DSRIP IDN Project Plan Implementation (PPI)

Progress on Required Activities, Key Milestones and Progress Assessment Checkpoints

IDN Team Partner Communications Infrastructure

In addition to the foundational changes made in supporting/monitoring achievement of DSRIP implementation plan deliverables last semi-annual reporting period, the IDN-3 Admin team provided each Member Entity with a monthly report template that includes the DSRIP key deliverables as well as the process and outcome targets outlined in their IDN sub-contract. The template asks for progress against the targets/deliverables, as well as barriers/challenges and mitigation strategies to achievement. These reports are due by the 7th of each month to allow the IDN to receive timely information to include in the required monthly, quarterly and semi-annual reporting.

The IDN Admin team has also provided each partner who has approved funding allocations an invoice template that is pre-populated with their approved funding by line item. Partners are expected to populate the monthly invoice template with the expenses they are invoicing the IDN for reimbursement, as well as providing appropriate back-up documentation. Each monthly invoice is due to the IDN by the 15th of each month. These invoices and back-up documentation support the IDN's reporting as well as allow the Finance Committee to receive "real-time" allocations to expenditures to support decision-making.

On a bi-weekly basis, the full IDN partner membership was provided a training matrix which highlighted opportunities for trainings primarily in support of completing the training requirements for multi-disciplinary core teams but also included other related trainings. These training matrices offered trainings from various sources, with multiple delivery methods, training lengths and intended for various audiences. The matrix was sent out bi-weekly as well as was highlighted during the monthly full IDN meeting so that partners had several ways to learn about the training opportunities.

In support of providing transparency to all IDN-3 stakeholders, inclusive of sponsor leadership, governance committees as well as the full IDN member entity partner population, monthly dashboards and partner performance data reports are shared. The monthly dashboards provide visual insight to the status of progress, by partner, in meeting the implementation deliverables. The intent of these dashboards is to ensure a consistent view to the status of the demonstration to all stakeholders to avoid any party being surprised as to where barriers are occurring and to solicit support in engaging partners who are lagging behind in deliverables. The partner performance data reports also provide transparency, by partner, to the progress made in meeting performance data reporting.

IDN Network Changes

Unfortunately, LaMora Psychological Associates decided to leave the IDN due to data sharing concerns. They submitted a formal letter in June outlining their concerns and decision, which was shared with DHHS.

Governance/Community Input

Community input is gathered in a number of different ways, inclusive of the governance structure in place for IDN 3. Since the development of the IDN in 2016, Member Entity partners are engaged in multiple ways, from seats on the 4 Governance Committees and Executive Steering Committee, to monthly Full IDN meetings. Governance Committees meet monthly, with the Community Engagement, Data/IT, Clinical and Finance Committees providing updates and recommendations to the Executive Steering Committee.

The IDN membership struggled with the funding uncertainties related to county contributions serving as matches to federal funds. Not receiving any funding allocations during this reporting period caused the IDN Governance to only fund previously approved strategies and funding allocations for SFY '20, based upon the 2017 project plan and budget decisions. There were numerous supplemental funding proposals submitted in the Fall 2018, which were vetted and recommended by the **Clinical Governance** committee to the **Finance Governance Committee**, but given the uncertainties for when and how much additional funding would be received in the coming months, the determination was made to review those supplemental proposals later in 2019 when more concrete funding information is known. However, to support increasing knowledge about the goals and early successes of the IDN, the Executive Director has been available to leverage the county representation on the IDN Executive Steering Committee to participate in meetings with county delegation members and provide information materials to support the questions they have had.

The **Data/IT Governance Committee** continued to meeting on a monthly basis during this reporting period and has been valuable in closing contracts with our vendors such as the [redacted] sponsorship agreement and in providing insight for evaluating technology for areas such as Closed Loop Referral and addressing partner barriers in implementation of the minimum required HIT capabilities. However, as the IDN transitioned from a planning and implementation phase to a performance based model starting CY 2019, the committee's focus transitioned from addressing general policies/guidelines and developing HIT infrastructure to data analytics and partner reporting performance. The IDN began presenting the committee a monthly partner HIT implementation status as well as monthly outcome measure and technology usage statistics which has led to identifying a need to form a Collaborative Advisory Sub-Committee. This sub-committee would include individuals representing various IDN partners as well as departments within each organization such as report writers, quality, clinical and decision makers with the goal of bringing together clinical and data/IT in order to holistically understand the DSRIP program patient centered and funding goals. It is also expected that the topics brought in front of this sub-committee will help to standardize reporting and use of technology across the IDN. This sub-committee is expected to be in place in August 2019.

In order to maximize the efforts of the **Clinical Governance Committee**, early on in this reporting period there was a review of committee membership and engagement levels to ensure participating member partners were committed to the responsibilities and goals of the committee. This led to outreach to member partner delegates to gain their agreement to commitment of their role, and the time needed from them in order to maximize the effectiveness of the committee. With this reinforcement, the committee was able to provide value on topics such as review of partner requested changes to their statements of work, development of a subcommittee work team to design IDN-3 recommended guidelines & protocols, support in encouraging partners to complete outstanding deliverables and input to supplemental funding requests.

In addition, the **Community Engagement Governance Committee** is in the process of conducting focus groups, providing education on health care access and IDN initiatives through radio and television shows, as well as wellness education events.

<u>Radio events</u>: Committee members will participate in up to 3 radio shows over the next 6 – 9 months, targeted to general audiences with information about the strategies being implemented by partner organizations to support integrated care and co-occurring disorders.

<u>Television events</u>: Committee members will participate in Cable Access Channel shows through a moderated panel of local experts and consumers. These shows can be uploaded to YouTube, as well as on IDN partner organization websites and social media outlets. The audience includes the general

community, including Medicaid beneficiaries and their caregivers with education about changes in health care as a result of IDN initiatives, with a focus on mental health, suicide, substance use disorders, wellness and health care access.

Focus Groups: Focus groups will be conducted at up to 4 locations in the greater Nashua community, using existing participants/stakeholders already engaged with IDN member entities. The target audience are Medicaid beneficiaries, individuals diagnosed with behavioral health conditions and their friends and family member, and home care providers. Initial audiences include those engaging with the peer support agencies in the region, NAMI NH support groups, and Life Coping home care providers. The purpose is to gather feedback from community stakeholders (consumers, family/friends, caregivers, providers) about their perceptions of progress from the DSRIP demonstration waiver, including areas of strength and those in need of additional focus.

Wellness Education Events: Two wellness events are being planned for October (Mental Health Awareness month) that will feature a speaker (likely a physician or other provider) and focus on the feedback received from the focus groups. Participants will be selected through IDN member providers "inviting" their clients/patients, with target numbers for each IDN provider up to 85 participants in total for each event. The goal of each of the 1.5 – 2 hour sessions is to provide education to Medicaid beneficiaries and their caregivers about changes in health care as a result of IDN initiatives, with a focus on mental health, suicide, substance use disorders, wellness, and health care access.

The IDN continues to hold monthly **Full IDN meetings** which are open to all IDN members. The meetings are held in person once per quarter with the other two months within the quarter being held via webinar. This meeting frequency allows timely updates to the membership inclusive of announcements of interest, the evolution of the county funding situation and upcoming trainings for them to consider participation in. Additional topic areas typically include updates on the learnings from [redacted] data analysis, partner status updates on meeting DSRIP commitments and goals, upcoming deadlines to consider, a pertinent training topic, and an opportunity for an IDN partner to highlight their organization via the "Partner Spotlight" segment. Surprisingly the feedback to the "Partner Spotlight" has been a true better understanding of the services of the partner and how other IDN member organizations can leverage their programs and services.

Opioid Crisis Update

Hillsborough County (of which IDN 3 contains 13 of the 31 towns) did see improvement areas as others continue to be a challenge in drug-related incidents, including Narcan administration by EMS, opioid-related emergency department visits and treatment admissions, as can be seen below.

Comparing year over year, there seems to be a decrease in the use of Narcan in 2019 over 2018 during the same periods.

Hillsborough County Narcan incidents with EMS*:

Month	2018	2019
January	69	63
February	81	83
March	95	79
April	81	69
May	92	80
June	70	Not Avail.

Opioid-related Emergency Department visits*:

Month	2018	2019
January	239	176
February	174	148
March	174	180
April	161	190
May	177	205
June	151	Not Avail.

Opioid-related treatment admissions*:

Month	2018	2019
January	76	68
February	57	72
March	59	77
April	53	108
May	63	85
June	85	Not Avail.

Nashua Safe Stations, a project of the Partnership for Successful Living (an IDN Member Entity), reported the following as of June 04, 2019**:

Month	Q1 & Q2 2018	Q1 & Q2 2019
Number of requests for Nashua Safe Station	593	432
Number of participants transported to hospital ED:		
SJH	26	3 8
SNHMC	27	44
Percentage of participants transported to hospital ED	9.5%	20%
Number of participants taken to Substance Misuse Treatment Facilities	538	347
Average Length of Time Nashua Fire and Rescue (NRF) Company "Not Available":	9.4 Min	9.3 Min
Number of UNIQUE participants	455	335
Number of REPEAT participants	336	254
Gender Breakdown:		
Male	423	325
Female	170	107

*Source: Drug Environment Reports (May 2019 and December 2018) from https://www.dhhs.nh.gov/dcbcs/bdas/data.htm
**Source: amr-nashua-report-06212019 from https://www.dhhs.nh.gov/dcbcs/bdas/data.htm

Project Plan Implementation (PPI) Budget

As can be seen from the Project Plan Implementation Budget Table below, the IDN has allocated funds across all calendar years, ending its projected budgets June 30, 2021. The Governance structure of the IDN worked throughout early 2017 to identify strategies and build budgets for all of those funding periods, tentatively approving funding allocations to individual IDN Member Entity organizations who had successfully submitted proposals and budgets that would address the milestones and deliverables outlined in the Special Terms and Conditions (STCs), as well as what was identified by the 2016 Community Needs Assessment and the IDN members themselves.

A1: Behavioral Health Workforce Capacity Development

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $3,271,373.22

- CY 17 (July – December 2017): $770,081.59
- CY 18 (January – December 2018): $1,075,708.33
- CY 19 (January – December 2019): $743,349.04
- CY 20 (January – December 2020): $682,234.36

Total funding expended (July 2017 – June 2019): $1,218,056.90

- CY 17 (July 2017 – December 2017): $46,922.00
- CY 18 (January 2018 – December 2018): $622,933.95
- CY 19 (January 2019 – June 2019): $548,201.00

A1 project strategies and subsequent funding allocations were made to numerous IDN Member Entity provider partners within several budget line items, including:

- recruitment/hiring
- retention
- preceptor/licensing supervision
- workforce development and training
- other integrated health team support services.

More detailed budget information is provided in the A1 section of this report.

A2: Health Information Technology (HIT) Infrastructure to Support Integration

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $1,972,046.44

- CY 17 (July 2017 – December 2018): $167,999.90
- CY 18 (January 2018 – December 2018): $931,673.46
- CY 19 (January 2019 – December 2019): $436,186.56
- CY 20 (January 2020 – December 2020): $436,186.56

Total funding expended (July 2017 – June 2019): $397,265.34

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $257,917.34
- CY 19 (January 2019 – June 2019): $139,348.00

A2 project strategies and subsequent funding allocations were mostly made to HIT vendor platforms to support the data warehouse/Quality Reporting Service and event notification/transmit notification service, however, some funds were expended by individual IDN Member Entity provider organizations to support:

- data extraction/validation to develop reports to meet DHHS and IDN metrics
- query/response CCSA exchange.

More detailed budget information is provided in the A2 section of this report.

B1: Integrated Healthcare

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $5,551,246.68

- CY 17 (July 2017 – December 2017): $763,959.00
- CY 18 (January 2018 – December 2018): $1,672,841.24
- CY 19 (January 2019 – December 2019): $1,571,673.24
- CY 20 (January 2020 – December 2020): $1,569,173.24

Total funding expended (July 2017 – December 2018): $701,927.00

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $303,213.52
- CY 19 (January 2019 – June 2019): $399,713.00

B1 project strategies and subsequent funding allocations were mostly allocated to support workforce to build the staffing capacity to achieve the integrated health goals of achieving Coordinated Care Practice designation and move toward Integrated Care Practice designation. However, there were funds allocated to support capital improvement, legal, and consultant expenses for the InteGreat Health Co-Located pilot

practice, as well. Indirect costs are also included in these funding allocations, capped at 15% (as approved by the IDN Executive Committee. More detailed budget information is provided in the B1 section of this report.

C1: Care Transitions (Critical Time Intervention)

Total proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $788,231.90

- CY 17 (July 2017 – December 2017): $61,798.70
- CY 18 (January 2018 – December 2018): $242,144.40
- CY 19 (January 2019 – December 2019): $242,144.40
- CY 20 (January 2020 – December 2020): 242,144.40

Total funding expended (July 2017 – December 2018): $219,121.18

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $78,580.18
- CY 19 (January 2019 – June 2019): $140,541.00

Critical Time Intervention (CTI) strategies and subsequent funding allocations mostly entail staffing expenses, including salary/wages and benefits, travel reimbursement, computers, and cell phones. Additionally, funding was allocated to support office supplies and client-related emergency expenses, as well as indirect costs, capped at 21% (as approved by the IDN Executive Committee). They also include funding to support interpretation services. More detailed budget information is provided in the C section of this report.

D3: Expansion in SUD Treatment Options

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $784,003.00

- CY 17 (July 2017 – December 2017): $84,367.00
- CY 18 (January 2018 - December 2018): $233,212.00
- CY 19 (January 2019 – December 2019): $233,212.00
- CY 20 (January 2020 – December 2020): $233,212.00

Total funding expended (July 2017 – December 2018): $149,827.87

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $80,257.87
- CY 19 (January 2019 – December 2019): $69,570.00

Funding associated with this project include support staffing-related expenses, including salary/wages and benefits, travel reimbursement, computers and cell phones, as well office supplies and indirect costs, capped at 15% (as approved by the IDN Executive Committee). More detailed budget information is provided in the D section of this report.

E4: Integrated Treatment for Co-Occurring Disorders (IDDT)

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $617,256.82

- CY 17 (July 2017 – December 2017): $40,784.42
- CY 18 (January 2018 – December 2018): $244,706.52
- CY 19 (January 2019 – December 2019): $165,882.89

- CY 20 (January 2020 – December 2020): $165,882.89

Total funding expended (July 2017 – December 2018): $350,941.69

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $136,991.69
- CY 19 (January 2019 – December 2019): $213,950.00

Funding associated with this project include mostly staffing-related expenses, including salary/wages and benefits, travel reimbursement, computers and cell phones, as well as office supplies and indirect costs, capped at 15% (as approved by the IDN Executive Committee). More detailed budget information is provided in the E section of this report.

For the remaining years of the DSRIP demonstration, projected funding allocations for all projects are broken down equally across 24 months, with the expectation that as we move into the coming months, we will become more certain of how the funding needs will change for our partners to meet the DSRIP performance outcome measures.

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				

Project A1: Behavioral Health Workforce Capacity Development

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

See attachment_A1.3a Workforce Capacity Building Implementation Plan

Implementation Plan Key Milestones

IDN-3's Workforce Capacity Building Implementation Plan focuses on 4 key areas:

- Workforce recruitment, hiring and retention
- Integrated care supports
- Statewide Workforce Taskforce efforts
- Training, education and professional development

Workforce: Recruitment, Hiring and Retention

Progress

In general, IDN-3 provider organizations have made progress in on-boarding new and/or vacant positions to support IDN-related strategies, with success in retaining many IDN-funded staff, thereby maintaining a platform for continuity in progress towards integrated care. This progress has been made possible through use of IDN incentive funds by multiple partners to support their recruitment, hiring and retention efforts, including use of funds for:

- dues/fees for ads with professional organizations and on recruitment sites
- staff referral and sign-on bonuses
- CMEs/professional development fees
- license fees/dues
- stay incentives/retention bonuses
- student loan repayment
- staff recognition efforts.

Dartmouth Hitchcock, Lamprey Health and Ascentria Care Alliance have all secured Community Health Workers (or similar type roles) since January and are in varying stages of the onboarding process with each. These CHWs are playing/will play varying roles for their organizations, from spending significant time in the community providing case coordination and health education, to providing screenings to supporting the CCSA and related referral pathways in the office environment. Up until this point, neither Dartmouth nor Lamprey Health have executed CCSAs due to this staffing shortage; hence the addition of these roles is anticipated to have positive impact in achievement of performance outcome measure progress in the next reporting period.

Progress made in the recruitment, hiring and retention of related IDN incentives includes:

Ascentria Care Alliance

- Recruit/Hire: with their original CHW accepting a residency role in internal medicine out-of-state in May, Ascentria quickly backfilled their IDN-funded CHW position to allow for training/orientation time. This allowed for a seamless experience for their caseload of refugees and new immigrants.
- Retention: their additional 2 partially IDN-funded roles (trainer and administrative supervisor)

have been retained.

GNMHC

- Recruit/Hire: use of IDN funds for sponsored/targeted ads for online recruitment and advertising with professional associations resulted in hires for an APRN, therapists, case managers, ACT Team Coordinator, clinicians, a Supported Employment Specialist, therapists, Mental Health Counselors, and a Drug Court Clinician. These funds also supported:
  - 13 sign-on bonuses for APRNs, nurse practitioners, case managers, therapists
  - 14 licensing fee reimbursements for therapists, MLADCs, nurses
  - supervision stipends supporting 5 staff working towards MLADC, 1 of whom obtained the MLADC this reporting period
  - 1 paid internship continued through this period and resulted in the intern being hired as staff in June
- Retention: numerous staff have been retained since the IDN began, including:
  - 13 employee recognition awards for time served at the agency
  - 7 staff referral bonuses
  - 2 retention bonuses (1 for psychiatrist)
  - ongoing work through the period with the Compensation Consultants resulting in market rate adjustments to all positions within the agency and current work on updating job description
  - to retain supervisors and impact their ability to retain their supervisees supervisors received further education and support around Situational Leadership that began in previous 6 month period

Lamprey Health

- Recruit/Hire: had their InteGreat Health CHW role posted for over a year, searching for an ideal candidate who was multi-lingual with behavioral health experience to support Lamprey's patient population with an individual being hired in April and beginning role part time during April/May while they completed their Bachelor's Degree in Public Health (transitioned to full time in late May). Use of IDN-funded sign-on bonus was leveraged to support the hiring of their CHW role, as well as use of licensing fees/dues and CMEs/professional development fees to support their mental health practitioner and Physician Assistant.
- Retention: has retained their InteGreat Health Project Manager/Clinical Care Coordinator since May 2017 and Case Manager since June 2018.

NAMI NH

- Retention: has retained their IDN-funded Family Peer Support Specialist since July 2018, including use of IDN funds for professional development activities.

The Emmaus Institute

- Recruit/Hire: their IDN-funded part time Administrative Assistant left their practice but was backfilled with an alternate resource quickly during this reporting period.
- Retention: has retained their 2 partially IDN-funded Licensed Pastoral Psychotherapists to support their enhanced individual therapy, community-based spirituality non-treatment groups in two locations across the IDN, as well as trainings for providers (Spirituality in Patient Care) and faith community (Bridges of Hope with NAMI NH and Pastoral Care Specialist with AAPC) throughout the IDN region.

The Youth Council

- Retention: has retained their 2 Project IMPACT Master's Level clinicians for 2+ years in the Nashua Middle Schools through use of professional development, supervision stipends, and student loan repayment IDN funds. They have also retained their MLADC who is focused on addressing the gap

in clinical services (screening/assessment, individual therapy, and case management) for adolescents.

Barriers/Challenges and Mitigation Plans:

Maximizing use of IDN funds toward building workforce capacity and achieving workforce/staffing targets, continues to be a challenge. The narrative in section A1-5 summarizes the barriers/challenges associated with those gaps, as well as the IDN's mitigation strategies (if applicable) to meet the identified targets.

Integrated Care Supports

Project A1 funding is also supporting several integrated health initiatives. Below is a summary of the progress in these strategies/initiatives.

Supporting clinical expertise for case management for patients with intellectual/developmental disabilities

Gateways Community Services and Greater Nashua Mental Health have spent several months working towards an MOU with its completion in May, which now formalizes their partnership and approach in supporting individuals with intellectual/developmental disabilities and behavioral health disorders. This population has unique challenges which require specific expertise in order to properly support the client base. Clinicians from the two organizations meet regularly each month to review the most complex of their shared 29 clients/patients. The IDN-funded (stipend) Clinical Case Consultant in is supporting the process of developing further tracking techniques to identify and track those clients/patients who are high ED utilizers (4+ visits per year) and determine if this new formalized relationship supports a reduction in those visits.

Supporting clinical expertise for those patients who could benefit from spirituality/faith based resources

IDN-3 funding to The Emmaus Institute resulted in the development and enhancement of weekly community-based spirituality groups (through both A1 and D3 project funds). Attendance by community members varies, with a combination of repeat participants and first-timers, including individuals in varying stages of recovery from substance misuse and mental health disorders, challenging housing situations and varying levels of isolation. The sessions are facilitated by a Licensed Pastoral Psychotherapist as well as a participants from the IDN-funded Pastoral Care Specialist training series (completed in Spring 2018). The weekly sessions are held at IDN Member Entity Revive Recovery Center (attracting 38 unique individuals) and Nashua United Methodist Church (attracting 18 unique individuals). Discussions are underway to broaden the Spirituality Groups to include facilitation by Swahili pastors for a congregation of Swahili speaking congregants. Although no intentional assessments or referrals have been made there are plans to consider to make that offer to participants in the future.

Additionally, The Emmaus Institute conducted a Lunch & Learn presentation on Spirituality in Patient Care attended by 35 clinicians and support staff from Lamprey Health. The intent of these trainings is to increase knowledge and responsiveness of healthcare providers/support staff to the spirituality needs of patients as part of an integrated care setting. According to Emmaus, "Research has demonstrated that religious beliefs and activities are often valuable resources that help patients cope with difficult situations and may be utilized by mental health specialists to help speed recovery from emotional illness or maintain remission."

Note: A1 funded enhanced individual therapy provided by The Emmaus Institute will be included in the B1 section.

Supporting a CHW to provide care coordination and connections to primary care, behavioral health and social services to refugees and immigrants

Refugees and new immigrants have a unique set of challenges in the achievement of integrated care. With that in mind, IDN funding has been provided to Ascentria Care Alliance to support a CHW (1 FTE). This support includes case management, care coordination, health education, transportation, language interpretation and referrals (fuel assistance, employment services, housing, Medicaid, SNAP, etc.). Additionally, Ascentria is using the RHS-15 and the MN Mental Health Screener (both specifically designed for refugee populations) to not only test the effectiveness of each, but also to determine appropriate referrals to Lamprey Health, who provides primary care services to this population in IDN 3. Initially, Ascentria Care Alliance had targeted a caseload of up to 60 clients, but due to the complexity of the individual caseloads, including language barriers to lack of understanding of behavioral health conditions, a caseload of only ~30 clients are able to be supported at any given time, causing individuals to be turned away who could benefit from this level of support and guidance.

Additional support is provided to this population via an alternate approach – that of education and training to the community as it relates to cultural differences. Twelve cultural competency-related trainings were held for IDN members and the general community by an IDN-funded Cultural Effectiveness Trainer (CET) with the intent to educate providers and other community-based stakeholders in cultural competency and adaptation to increase their awareness and knowledge. Based on post-training evaluations, the ~200 training attendees feel they are now a bit more culturally aware than they were in the past.

Allocate funding to support increasing the BH workforce through internships and preceptor opportunities including intern stipends

Both Greater Nashua Mental Health and The Youth Council continue to be successful in retention of their 2 interns via IDN-3 funding to support monthly intern stipends and related expenses, as well as supervision. Additionally, Lamprey Health has leveraged IDN funding to support CMEs and supervision stipends to move their InteGreat Health Physician Assistant to certification.

Allocate funding to support increasing the number of MLADCs who can provide substance use treatment via allocations to offset additional supervision/non-productive clinician time

Greater Nashua Mental Health actively leverages IDN funding to support increased capacity needed for supervision through providing stipends to increase capacity and support 8 staff working towards higher licensure, with 2 of those individuals now completing their MLADC during this reporting period.

Supporting screenings/supportive counseling/referrals to students in the Nashua Middle Schools

The Youth Council continues to employ 2 Student Assistance Counselors via use of IDN funds who interact with middle school adolescents, execute CCSAs where applicable, generate referrals to PCPS for well-care visits, psychologists for neuro-psych evaluations and medication management through psychiatrist support.

Identifying strategies for utilizing/connecting existing SUD and BH resources

With the purpose of educating and connecting IDN partner members regarding the services and integration opportunities between SUD and BH resources, IDN-3's monthly Full IDN meeting includes a "Partner Spotlight" where a single partner takes ~15 minutes to highlight themselves; most recently Merrimack River Medical Services and The Emmaus Institute were able to market themselves and develop/reinforce opportunities. After each presentation there was notable activity of interactions between partners and the presenter.

Progress has made towards the IDN goal to enhance the partnership between Southern NH Medical Center's Acute Care Case Manager and GNMH as it relates to information to be populated in a shared care plan in support of individuals coming into the ED. Multiple discussions have been held and it's been acknowledged that the ED, simply knowing the name of the assigned case manager, as a starting point, supports patient care as well as is a stepping stone towards SCP development.

Statewide Workforce Taskforce

In support of the statewide efforts for workforce capacity building, IDN-3 has been actively engaged in the Statewide Workforce Taskforce via project team member participation on the policy, education and training and recruitment/hiring sub-committees.

Policy subcommittee (member participant on subcommittee)

- Collaboration with state legislators in drafting legislative language, specifically providing written and verbal testimony for SB 180 regarding privileged communication. Successfully signed into law July 2019.
- Advocate for legislative changes via active engagement with presentations to appropriate boards and legislative bodies
- Participation in recurring subcommittee meetings

Recruitment & Hiring subcommittee (chair of subcommittee)

- The small R&H subcommittee, made up of 3 other IDN region members and a representative from Bi-State Primary Care, meets monthly and reviews an active work plan highlighting the progress, barriers and plans to overcome.
- Over the course of this 6-month reporting period the subcommittee completed/closed out 9 items on their work plan with the oversight and approval of the broader workforce taskforce committee members. Some of these completed/closed items included:
    - Engagement with AHEC's review/development/release of an updated version of their Healthcare Catalog (scheduled for fall 2019) which supports completion of the "Collection of and compilation of a shared repository of integrated care job description samples" and "Statewide usage of similar language both verbally and in written documents to mitigate confusion and improve understanding."
    - Development of a document which highlights resources for healthcare employers to pass along to candidates during their recruitment activities and specifically supports the needs of a trailing spouse/partner. This completed activity addressed "Partnering with healthcare and non-healthcare employers to identify opportunities for trailing spouses/ partners" and resulted in a broad distribution to the state's IDN Admin Leads as a reference point to further distribute as they saw appropriate.
    - Distribution of a peer career path resource document to the state's IDN Admin Leads providing a framework of the roles and stepping stones from peer roles and the associated

licensure/education requirements for them to consider providing to their community members with the intent of addressing "Educating community members that personal life experiences can be part of the training needed for a behavioral health career" and "Working with peer organizations to develop career pipelines."

Workforce: Training, Education and Professional Development

Progress

Supporting training for the multi-disciplinary core team (MDCT) members to build awareness, knowledge and skills to support goals of IDN:

In support of making progress on multi-disciplinary core team member participation in required training, the admin team worked closely with New Hampshire Healthy Families (NHHF) and other IDN colleagues across the state to gather information on and publicize a multitude of training topics via various delivery methods. Every other Friday a training matrix was distributed via email and reinforced during the monthly Full IDN meetings. As planned at the end of the prior reporting period, the following steps were taken to prompt more participation in trainings:

- provide a more diverse delivery format for training opportunities by:
- incorporating shorter trainings (1-2 hours in length) and
- providing access to more webinars and self-paced development opportunities and
- leveraging organization's existing internal training as well as individual provider's professional development opportunities and licensing requirements to leverage meeting required training content.

This approach provided a strong, continuous training offering of >60 training opportunities over 6 months to partner members. These trainings included multiple A1-funded offerings in CCSA/ Universal Screening, Understanding Addiction, Care Planning/Care Coordination, Co-Occurring Disorders, Mental Health First Aid, Cultural Competency. This resulted in strong participation but continued limited MDCT members meeting training requirements. Even with training being discussed during individual monthly partner meetings, incentivizing MDCT participation was a struggle.

Training non-clinical IDN staff in Mental Health First Aid:

Mental Health Awareness, Mental Health First Aid and Youth Mental Health First Aid training opportunities to non-clinical staff, IDN-3 sponsored 4 full-day trainings which drew >100 attendees. Additionally, the biweekly publication of available trainings included reference to pre-recorded mental health awareness webinar materials from IDNs 1 & 2 which could be accessed at an individual's preferred timeframe.

Increasing awareness in the diversity of cultures

Twelve cultural competency trainings, attracting over 200 attendees, took place across the IDN-3 region with varying audiences including individual partner practices, Community Emergency Response Team volunteers, a college Policy and Politics class and college healthcare students. The training topics included:

- Unpacking Assumptions
- Stigma Across Cultures
- Cultural Forum
- Cross Cultural Perspectives

Supporting professional development:

IDN-3 has funded the following organizations for staff professional development:

- Ascentria
- Gateways
- Greater Nashua Mental Health
- Lamprey Healthcare
- NAMI NH

These organizations leveraged this funding for professional development related to training of:

- 2018 Psychopharmacology: Everything the Non-Profit Needs to Know
- Animal Assisted Therapy
- Certified Clinical Trauma Professional
- Chronic Anxiety: Powerful Treatment Methods
- Cognitive Behavioral Therapy Training
- Confabulation & Delusions
- CPR training
- DBT training for Non-DBT Providers
- DBT Skills Training for Borderline Personality Disorder
- DBT Conference
- DBT Skills Training for Borderline Personality Disorder
- Easter Seals Clinical Foundations Training
- HIV Trends and Treatment
- It Takes a Village: Teen SUD
- LEAP Training
- Legal & Ethical Issues w/Technology
- Mastering the Anxiety Game in Clinical Practice
- NCI 4 Day Classroom Instructor Certification
- New England School of Addiction and Prevention Studies
- NH Behavioral Health Conference and Public Policy Summit Professional Ethics
- Recovery Coach Academy
- Suicide and Self-Harm
- Trauma-Informed Yoga in Mental Health Clinical Practice

Supporting training/technical assistance for Critical Time Intervention (CTI) team to implement strategies for care transitions, including intensive case management with clients diagnosed with SMI as they transition from IDN emergency departments and NH Hospital back to the community

- CTI Supervisor training (5/4/19) attended by a member of the Greater Nashua Mental Health CTI team
- Monthly Community of Practice gatherings (virtual and in-person) provided support and assistance in hearing/sharing regional progress, barriers along with guest speakers; participation by GNMH CTI team members varied by month
- Individual 1:1 technical assistance provided as needed
- Fidelity assessment & monitoring

Supporting training for general IDN/community members:

The biweekly training matrix, delivered via email to the Full IDN membership (~175), highlighted the available training opportunities of which most were available to any/all members and their staff, which resulted in >300 unique, general IDN/community members participated in the broad offering of training topics.

The Community Engagement Committee developed a 4-component community outreach plan including participation in/facilitation of:

- Television programs (slated for July)
- Provide education about changes in healthcare as a result of IDN initiatives w/focus on mental health, suicide, SUD, wellness, access and utilization
- Radio programs (slated for July)
- Provide education on healthcare , access and IDN initiatives
- Focus groups (slated for September/October)
- Gather feedback from community stakeholders (consumers, family/friends, caregivers, providers) regarding progress of the waiver implementation (areas of strength, areas in need of focus)
- Wellness education dinners (slated for October)
- Provide education to Medicaid beneficiaries and their caregivers about changes in healthcare as a result of IDN initiatives with focus on mental health, suicide, SUD, wellness, access and utilization.

Barriers/Challenges and Mitigation Plans:

Issue: continued challenges with engaging multi-disciplinary core team members in the required training. Although numerous learning opportunity delivery methods were offered (in-person, webinar and pre-recorded webinar) core team members were difficult to attract to the trainings. Although there was discussion regarding incentivizing clinicians to participate, a strategy and plan to implement incentives were not developed.

Mitigation: follow through on developing incentive program to attract MDCT members to meet their training requirements leveraging successful programs used by fellow IDN regions; this will include gaining funding approval and development of a process

Issue: anticipated support for training/technical assistance for the Integrated Dual Diagnosis Treatment (IDDT) team was not met this reporting period due to lack of subcontracting with Case Western due to budget uncertainty

Mitigation: continued prioritization of the benefits of this training with the appropriate governance committees

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

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Workforce Recruitment and Hiring: Increased knowledge among educators and students about the workforce opportunities available in the physical health and behavioral health integrated care field.	The Youth Council and Greater Nashua Mental Health Center will identify up to 3 new contacts at higher education institutions by 12/31/18 to reach out and engage them in the internship, preceptor and workforce opportunities in the IDN.	Achieved in prior reporting period, through outreach with Rivier University, University of New Hampshire and Boston University	Achieved in prior reporting period, however there was additional progress via continued engagement with Rivier University and Nashua Community College via IDN-funded cultural competency trainings to nursing students and students in various healthcare programs
Workforce Recruitment and Hiring: Increased knowledge among educators and students about the workforce opportunities available in the physical health and behavioral health integrated care field.	The Youth Council and Greater Nashua Mental Health Center will initiate opportunities to provide 8-month internships to up to 6 Master's Level interns by December 31, 2018 to engage them in the child and adolescent work of The Youth Council and GNMHC related to the IDN's work in the field of integrated behavioral health.	Achieved: Both The Youth Council and GNMHC initiated opportunities resulting in employment of 2 interns each (4 total) with each retaining 1 intern each (2 total)	Achieved in prior reporting period, however there was additional progress via retention of interns by GNMHC & The Youth Council
Workforce Recruitment and Hiring: Increased knowledge through broadening the geographic area of reach for potential workforce to support the work of the IDN.	Up to 100 individuals will participate in the efforts related to the IDN's Career Fair, including attending the event(s), inquiring about posted jobs, and engaging with IDN Member Entities regarding IDN- funded positions by December 31, 2018.	Achieved in prior reporting period, with 70 individuals who RSVP'd and/or attended the 2017 Career Fair	Achieved in prior reporting period
Workforce Recruitment and Hiring: Increased knowledge through broadening the geographic area of reach for potential workforce to support the work of the IDN.	Up to 30 potential qualified applicants will provide their resumes, indicating interest in the available IDN- funded positions by December 31, 2018.	Achieved in prior reporting period, with 37 resumes received via the IDN 3 website and the IDN 3 Career Fair	Achieved in prior reporting period, however there was additional progress due to volume of qualified applicant outreach to Dartmouth Hitchcock and Lamprey Health for Community Health Worker roles
Workforce Recruitment and Hiring: Increased knowledge through broadening the geographic area of reach for potential workforce to support the work of the IDN.	Up to 10 IDN-funded positions will be filled through the efforts of the Career Fair(s) and IDN website's Career Board by December 31, 2018.	Achieved: Positions filled at Dartmouth Hitchcock, Greater Nashua Mental Health Harbor Homes, Lamprey Health, NAMI NH, and The Youth Council	Achieved in prior reporting period

Workforce Recruitment and Hiring: Increased knowledge through broadening the geographic area of reach for potential workforce to support the work of the IDN.	Up to 6 IDN Member Entities will utilize IDN funding to support dues or fees for recruitment sites, services and social/print media campaigns, resulting in the hiring of up to 6 positions to support IDN strategies by December 31, 2018.	Achieved: IDN funds have been utilized to support dues/fees for recruitment efforts, resulting in successfully onboarding more than 6 positions.	Achieved in prior reporting period, however progress continued with GNMHC utilizing IDN funds for targeted online recruitment ads and professional association ads for the hiring of multiple roles
Workforce Recruitment and Hiring: Increased incentives for behavioral health workforce to work in NH (from both within and outside of the state).	Up to 9 IDN Member Entities will utilize IDN funding to provide sign-on bonuses for up to 9 newly hired staff to support IDN strategies by December 31, 2018.	Achieved: GNMHC allocated IDN sign-on bonuses to 9 newly hired staff	Achieved in prior reporting period, however progress continued with Lamprey (CHW) & GNMHC (13 various roles) utilizing IDN funds to provide sign-on bonuses to new hires
Workforce Recruitment and Hiring: Increased incentives for behavioral health workforce to work in NH (from both within and outside of the state).	IDN funding will be utilized to support an IDN Member Entity in their HR staffing capacity to develop job descriptions, and interview/onboard new staff, resulting in the hiring of up to 4 positions to support IDN strategies by December 31, 2018.	Achieved: 2 member entities leveraged IDN HR-staffing support dollars resulting in new hires	Achieved in prior reporting period
Workforce Recruitment and Hiring: Increased incentives for behavioral health workforce to work in NH (from both within and outside of the state).	Up to 3 IDN Member Entities will utilize IDN funding to support reimbursement of relocation expenses, resulting in the recruitment and hiring of up to 4 positions to support IDN strategies by December 31, 2018.	Not Achieved: No member entities utilized IDN-funded relocation funds resulting in hires, however the GNMHC utilized IDN funding to support a Compensation Analyst to provide an analysis of comparable organizations regarding compensation and/or incentive packages and provide suggestions for how to attract and retain staff.	Not Achieved: No member entities utilized IDN-funded relocation funds resulting in hires, however funds are still available to support these efforts in the next reporting period for GNMH.
Workforce Recruitment and Hiring: Increased incentives for behavioral health workforce to work in NH (from both within and outside of the state).	Up to 2 IDN Member Entities will utilize IDN funding for staff referral bonuses to incentivize existing staff to refer potential new workforce members, resulting in the hiring of up to 2 positions to support IDN strategies by December 31, 2018.	Achieved: GNMHC allocated IDN referral bonus funds resulting in 2 new hires	Achieved in prior reporting period
Workforce Retention and Sustainability: Increase in the number of MLADCs who can provide substance use treatment in the IDN.	Up to 6 Licensed Alcohol and Drug Counselors (LADCs) will be supervised by IDN Member Entity organizations who will receive stipends from IDN funding to support their supervision requirements.	Achieved: GNMHC received supervision stipends for supervising 6 LADCs working toward becoming an MLADC	Achieved: IDN 3 has 2 new MLADCs at GNMH through use of IDN funds to support supervision stipends.

Workforce Retention and Sustainability: Increase in the number of MLADCs who can provide substance use treatment in the IDN.	Up to 2 of the LADCs receiving supervision through the IDN-funded supervisors will have the opportunity to be hired by IDN Member Entities as newly licensed MLADCs by December 31, 2018.	Achieved: GNMH on-boarded one MLADC who had been supervised as LADCs	Achieved: IDN 3 has 2 new MLADCs at GNMH through use of IDN funds to support supervision stipends.
Workforce Retention and Sustainability: Increased perception of empowerment and value among existing behavioral health workforce for the work they are doing to support the IDN strategies.	Up to 15 staff (a combination of new and existing staff) will utilize IDN funding for CMEs/CEUs and/or professional development by December 31, 2018.	Achieved: GNMH provided CMEs/professional development funds to 22 staff and licensing fees and/or professional dues to 1 staff during the reporting period	Achieved in prior reporting period, however there was continued progress with GNMHC providing CMEs/professional development funds to 12 staff and licensing fees to 5 staff; as well as Lamprey Health and The Youth Council utilizing IDN funds to support 1 staff member each.
Workforce Retention and Sustainability: Increased perception of empowerment and value among existing behavioral health workforce for the work they are doing to support the IDN strategies.	Up to 7 staff receiving financial support for association professional dues and/or medical licensure fees will be documented as staying in their positions with IDN Member Entities for a minimum of 24 months.	Achieved: IDN funds have been utilized for 15 staff, with many of them having been retained in their positions since receiving these incentives.	Achieved in prior reporting period, however there was continued progress with GNMHC utilizing IDN funding to support licensure fee reimbursement for retention of staff having received licensure fee reimbursement.
Workforce Training and Education: Increased knowledge of providers and other stakeholders about the potential roles and opportunities to engage in the efforts of the IDN.	Up to 75 providers and community stakeholders will participate in the IDN's annual behavioral health conference, with at least 75% of completed surveys/evaluations reflecting an increase in knowledge about the roles and opportunities to engage in integrated health in the IDN.	Achieved: 76 community members attended the 10/10/18 Greater Nashua Public Health Advisory Council Annual Meeting, which was co-hosted by the IDN as its annual behavioral health conference	Achieved in prior reporting period.
Workforce Training and Education: Increased knowledge of providers and other stakeholders about the potential roles and opportunities to engage in the efforts of the IDN.	Up to 30 providers and community stakeholders will be trained through IDN training opportunities, including Mental Health First Aid, by December 31, 2018	Achieved: Two Mental Health First Aid trainings were held/ attended by 27 participants: 12/3/18 (17 participants) 11/5/18 (10 participants).	Achieved in prior reporting period, however there has been continued progress with Youth Mental Health First Aid held with the YMCA (20 camp counselors), and 3 additional MHFA sessions drawing ~80 community members.

Workforce Training and Education: Increased knowledge of providers and other stakeholders about the potential roles and opportunities to engage in the efforts of the IDN.	Up to 8 providers will participate in the Integrated Dual Diagnosis Treatment (IDDT) training provided by Case Western Reserve University over 4 days (Winter 2017 and Spring 2018) to increase their skills for implementing the model's stages of change and treatment for those with co-occurring Serious Mental Illness (SMI) and Substance Use Disorder (SUD).	Achieved: All members of the IDDT team participated in the Stages 1 and 2 training provided by Case Western Reserve University in September 2019.	Achieved in prior reporting period.
Workforce Training and Education: Increased knowledge of providers and other stakeholders about the potential roles and opportunities to engage in the efforts of the IDN.	Up to 4 providers will participate in the Critical Time Intervention (CTI) training over 2 days (Fall 2017 and Spring 2018) to increase their skills for implementing the model's 9-month intensive case management strategy.	Achieved: Achieved in prior reporting period, with 12 providers participating in the November 2017 and March 2018 CTI Staff training conducted by [redacted]	Achieved in prior reporting period, however the CTI team attended an additional supervisor training as well as attended monthly Community of Practice meetings.

A1-5. IDN-level Workforce: Staffing Targets

Provider Type	IDN Workforce (FTEs)					
	Projected Additional Workforce Needed for IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Psychiatrist	1.95	.26	.26	.76	.93	.82
Psychiatric APRN	1.3	0	0	0	0	0
Psychiatric Certified Nurse	1	0	0	0	0	0
Physician's Assistant (Certified)	0.2	0	0	.2	.2	.2
Nurse Practitioner	.28	0	0	0	.28	.28
Registered Nurse	1.7	0	0	0	.5	.5
Consulting Pharmacist	.2	0	0	0	0	.2
Medical Assistant	.28	0	0	.28	.28	.28
Licensed Therapist	6.02	0	4.75	4.78	4.99	4.96
Master's Licensed Alcohol and Drug Counselor (MLADC)	14	0	0	0	2	4
Behavioral Health Clinician/Specialist	18.6	0	4	4	14	17
Behavioral Health Coordinator	4	0	0	0	0	0
Case Manager	9.5	0	0	3	5	6
Care Coordinator	17.25	5	6	9	10.75	16.75
Community Health Worker	8.71	0	1	3	3	1.71
Criminal Justice Specialist/Liaison	0.1	0	0	.1	.1	.1
Supportive Employment Specialist	0.5	0	0	.5	0	.5
Housing Specialist	0.1	0	0	.1	.1	.1
Family Specialist	0.1	0	0	.1	.1	.1
Peer Support Specialist	1.53	0	0	1	1	1
Administrative Office/Billing	2.37	.75	1.1	1.37	1.1	1.1
Clinical Operations	.2	0	.2	.2	.2	.2
IT/Data Analyst, Manager, Operations	4.7	0	2.1	2.6	4.2	4.1
Program Evaluation Specialist	.5	0	0	0	.5	.5
Director	1.35	1.35	1.2	1.2	1.2	1.2
Project Manager	2.5	0	1.5	1.5	2.5	2.5
Marketing/Education	.20	0	.20	.20	.20	.20
Training Coordinator	0.5	0	.5	.5	.5	.5

There has been much success with recruiting/on-boarding and retaining the workforce to support IDN strategies. However, there have been numerous challenges/barriers. Below is a summary of the provider roles which have not been on-boarded and the IDN's mitigation plans to address them.

Psychiatrist

All of these gaps in meeting the targets were related to on-boarding/identifying psychiatric representation for individual MDCTs (Merrimack River Medical Services, St. Joseph Hospital and Physician Practices, and the Partnership for Successful Living), for which the IDN has allocated funds to support.

Barriers/Challenges: All of these providers have not yet executed IDN sub-contracts to allow their use of approved funding allocations, which has prevented them from on-boarding this provider role.

Mitigation Strategies: During the reporting period, the IDN has been working with the Clinical Governance Committee to identify protocols/workflows and processes for conducting a regional IDN MDCT. This was approved in June, to support those partners who have not yet stood up their MDCTs and/or require access to a MDCT, which includes those targeted to on-board the psychiatric role for their team.

The IDN expects to operationalize this monthly MDCT model in the next reporting period, with leadership from the IDN Clinical Governance Committee, as well as through sub-contracting with a clinical consultant.

Registered Nurse

Barriers/Challenges: The Partnership for Successful Living (Harbor Homes and Keystone Hall), who indicated they would on-board a detox nurse (.6 FTEs) and non-detox nurse (.6 FTEs) has not yet executed the IDN sub-contract to date.

Mitigation Strategies:

- The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets. During the reporting period, the IDN Governance Committees approved the changes in scope and budget. Revised project plans (which have been submitted to DHHS for review) reflect changes in the targets, with PSL noting that MLADCs are not billable under FQHCs, and therefore requesting to use supervision stipends to support staff moving to an LICSW or LCMHC.

Licensed Therapist

Barriers/Challenges:

- GNMH CTI Team Lead: previous role was a licensed therapist (1 FTE).
- GNMH Community-Based Groups Facilitator: In March 2019, GNMH notified the IDN that they would not be moving forward with implementing these weekly groups, so this strategy (and its designated staffing at .03 FTEs) will not move forward.

Mitigation Strategies:

- GNMH CTI Team Lead: GNMH has determined this team member could now become a Bachelor's Level role, serving 25% time administrative/supervision and 75% case management, with the addition of a .15 FTE Clinical Supervisor role.
    - The individual currently serving this role was previously a CTI Specialist who was moved to the Team Lead role, with a new individual filling their vacant role.

MLADCs

Barriers/Challenges: The gaps in hitting the targets for this provider type relate to lack of progress in the achievement of additional MLADC-certified staff outlined in our partners' project plans. This included:

- The Partnership for Successful Living (Harbor Homes and Keystone Hall), who indicated they would target up to 8 Master's Level clinicians who would benefit from IDN stipends to offset the supervision time of staff. They were not able to make progress in this target, due to not executing IDN sub-contracts with funds to support these strategies during the reporting period.
- Greater Nashua Mental Health, who indicated they would target up to 4 Master's Level staff achieving certification.
- Southern NH Medical Center, who has 1 Master's Level staff person targeted to achieve MLADC certification.
- LaMora Psychological Associates has struggled with meeting the NH State Statutes for data sharing related to this role (.03 FTEs) and has been working with the NH State Board, as well as their legal counsel to identify next steps to allow them to engage.

Mitigation Strategies:

- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets. During the reporting period, the IDN Governance Committees approved the changes in scope and budget.
  - Revised project plans (which have been submitted to DHHS for review) reflect changes in the targets, with PSL noting that MLADCs are not billable under FQHCs, and therefore requesting to use supervision stipends to support staff moving to an LICSW or LCMHC.
- GNMH has made significant progress in meeting their goals, with 3 out of the 4 staff members achieving MLADC certification.
  - GNMH has utilized IDN funding to support supervision stipends and will continue to receive these incentive funds into the next reporting period to support the remaining 1 staff member targeted to achieve MLADC certification.
- SNHMC's SUD Acute/Transitional Care Coordinator is still working on her certification, but not having achieved it to date. However, the IDN has provided additional funds to support her attendance at the New England School of Addiction and Prevention Studies in July.
- LaMora provided a formal letter in June 2019 requesting to be removed from IDN-3 due to its ethical challenges for sharing behavioral health data. This letter has been provided to DHHS to determine how this development affects the region's Medicaid attributed lives.

Behavioral Health Clinician/Specialist

There has been progress in on-boarding this provider role, with Dartmouth Hitchcock on-boarding their second clinician during this reporting period.

Barriers/Challenges:

- St. Joseph Hospital and Physician Practices (SJH) has not executed the IDN sub-contract to allow them to access B1 project funding allocations to support the adult (1 FTEs) and pediatric (.6 FTEs) behavioral health consultants. Their approved project strategies included potentially partnering with GNMH to support sub-contracting these roles.
- Both GNMH and The Youth Council were targeting up to 6 Master's Level interns who would support their intern cohort under this provider role, with 4 initially on-boarding in September 2018 and 2 subsequently leaving the cohort due to receiving other opportunities.
- The Youth Council received IDN funding to support 3 positions to support their Project IMPACT program in the Nashua Middle Schools. To date 2 of those individuals have been retained, with one leaving their role in early 2018.

Mitigation Strategies:

- The IDN continues to work with SJH to identify how to best move forward in their B1-related strategies, which include these 1.6 FTEs for behavioral health staff. With the ongoing challenges associated with the merger with Covenant Health and migration to a new EHR, SJH has shared that leadership is still trying to identify what makes the most sense for their organization moving forward to achieve the IDN deliverables.
- The Master's Level intern cohort funded strategy for GNMH and The Youth Council was only targeted to occur for the September 2018 – May 2019 academic year.
- The Youth Council Project IMPACT vacancy was filled through their D3 project goal of expanding access to SUD treatment for adolescents/young adults, so this role is now represented under the MLADC provider role category.

Behavioral Health Coordinator

Barriers/Challenges: The 2 FTEs under this provider role were part of the original project plans for Foundation Medical Partners (FMP) and Merrimack River Medical Services (MRMS).

- FMP determined it would not move forward with accepting IDN-approved funds to support this role as part of its B1 strategies and therefore, is utilizing its existing Master's Level Behavioral Health Clinicians/Specialists who are embedded in some of their practices to support their achievement of Coordinated Care Practice designation.
- MRMS has not yet executed its sub-contract with the IDN, but has had several meetings with the IDN Admin Lead that has included their Regional Vice President under Baymark, with who they merged in early 2018.

Mitigation Strategies:

- FMP: The IDN will continue to work closely with both FMP and their existing staffing capacity to document achievement of reaching Coordinated Care Practice designation and making progress toward Integrated Care Practice designation.
- MRMS leadership (including the delegate serving on the IDN Clinical Governance Committee) has indicated they are anxious to move forward with being an active member of the IDN and achieving Coordinated Care Practice designation and plans to continue to work together in the next reporting period to executive sub-contracts and achieve required deliverables.

Case Manager (Bachelor's and Master's Level)

Barriers/Challenges:

- GNMH has not on-boarded its .5 FTEs CTI Specialist, as the team feels it has not needed the additional capacity to date due to current enrollments.
- PSL identified 4 FTEs Integrated Care Case Managers to be supported by IDN funds in moving their three partner organizations (Harbor Homes, Keystone Hall and Healthy at Home) together toward Coordinated Care Practice designation. To date, IDN sub-contracts have not been executed and therefore, funds have not been released to support on-boarding these roles.

Mitigation Strategies:

- GNMC is working closely with the IDN and IDN-funded technical assistance provider/trainer, [redacted] to increase their enrollment and therefore the need to on-board their approved CTI Specialist (.5 FTEs) through engaging in 1:1 technical assistance/implementation coaching and fidelity training over the coming months.

- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets, with the IDN Governance Committees approving the requested changes during the reporting period.
    - These changes reflected not filling the 4 FTEs case managers and instead, outlining the need to support LPNs, LDACs, LICSWs, and/or CRSWs (3 FTEs). These project plan revisions are being reviewed by DHHS.

Care Coordinator (Bachelor's and Master's Level)

Barriers/Challenges: The remaining .5 FTEs Care Coordinator is associated with St. Joseph Hospital, as this role was approved as an emergency department SUD Acute/Transitional Care Coordinator. However, SJH has not executed their IDN sub-contract and scope of work for this D3 project funding allocation to date.

Mitigation Strategies: The IDN continues to work with SJH to identify how to best move forward in their D3-related strategies, which include this .5 FTE care coordinator in the emergency department, similar to what has been operationalized with SNHMC. With the ongoing challenges associated with the merger with Covenant Health and migration to a new EHR, SJH has shared that leadership is still trying to identify what makes the most sense for their organization moving forward to achieve the IDN deliverables.

Community Health Worker (CHW)

Barriers/Challenges:

- PSL identified 1 FTE CHW to be supported by IDN funds in moving their three partner organizations (Harbor Homes, Keystone Hall and Healthy at Home) together toward Coordinated Care Practice designation. To date, IDN sub-contracts have not been executed and therefore, funds have not been released to support on-boarding these roles.
- Dartmouth Hitchcock Community Resource Corps/Americorps VISTA: while IDN-3 partner organizations requested up to 5 CHWs under this program (to be allocated to Harbor Homes, SNHMC, GNMH, Nashua Department of Public Health, and St. Joseph Hospital and Physician Practices), only 2 were filled due to CHW interest and were subsequently placed with the Nashua Department of Public Health and St. Joseph Hospital.
    - These two CHWs ended their Community Resource Corps program with DH, with DH working with the IDN to potentially have a second round of CHWs, but this has not been confirmed to date.
- Dartmouth Hitchcock: These roles (under the title Resource Specialist) were targeted to support the MDCT and the implementation of the CCSA across the DH Nashua practices. One of the roles will be on-boarded in July 2019, with the other pending approval of supplemental funds requested by DH from the IDN.
    - Supplemental funding proposals were submitted in the Fall 2018 from numerous IDN Member Entities, with several being recommended by the IDN Clinical Governance Committee to move forward.

Mitigation Strategies:

- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets, with the IDN Governance Committees approving the requested changes during the reporting period.
    - These changes reflected not filling the 1 FTE CHW and instead, outlining the need to support LPNs, LDACs, LICSWs, and/or CRSWs (3 FTEs). These project plan revisions are being reviewed by DHHS.

- Dartmouth Hitchcock: The IDN continues to work with DH and its Governance Committees to get confirmation of county funding contributions as well as how its partners will actually expend approved funds to determine next steps in funding supplemental funding proposals such as the one provided by DH.

Peer Support Specialist

Barriers/Challenges: the gaps in the .53 FTEs for this role include the following:

- GNMH weekly pre-treatment community-based groups: In March 2019, GNMH notified the IDN that they would not be moving forward with implementing these weekly groups, so this strategy (and its designated staffing) will not move forward.
- GNMH IDDT strategy: GNMH has determined this position is not needed to meet program fidelity per technical assistance provided by IDN-funded technical assistance/training provider Case Western Reserve University.

Administrative Office/Billing

Barriers/Challenges:

- Foundation Medical Partners (FMP): 1 FTE Receptionist was targeted to support their B1 project allocation to move the organization and its designated practices forward with Coordinated Care Practice designation. However, FMP determined it would not move forward with accepting IDN-approved funds to support this role.

IT/Data Analyst, Manager, Operations

Barriers/Challenges:

- IDN Admin Lead (SNHMC) Data Analyst role (.10 FTEs) was contracted for several months in late 2018, but has since become vacant.
- PSL's Report Writer/Analyst (.5 FTEs) to support DSRIP Outcome Measure reporting and engagement in the other information sharing platforms has not been on-boarded due to lack of execution of the IDN sub-contract, which has staffing allocation funding to support this role.

Mitigation Strategies:

- IDN Admin Lead (SNHMC) Data Analyst role is currently being advertised to provide more capacity for the team as the waiver is now in pay-for-performance, and is replacing the recently vacated Integration Project Manager, which was funded as part of the A1 project. It is expected this role will be on-boarded by Fall 2019.
- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets, with the IDN Governance Committees approving the requested changes during the reporting period. The revised project plans are currently being reviewed by DHHS.

Director

Barriers/Challenges: the gap of .05 FTEs represents the IDN Admin Lead's Senior Administrative Sponsor, who retired in mid-2018 and has not been determined to need to be filled at this time.

Project Manager

Barriers/Challenges: the gap of 1 FTE represents the originally targeted DSRIP Quality Project Manager which was filled by one of the DSRIP Integration Project Managers. However, during the reporting period, one of the Integration Project Managers left their position.

Mitigation Strategies: It has been determined by the IDN Admin Lead that this project manager role needs to be filled by a different type of position (Data Analyst) to support the last half of the DSRIP demonstration. Currently, this position is being advertised and is expected to be on-boarded by Fall 2019.

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

The focus of funding allocations for this project funding source consists of several budget line items, including recruitment/hiring, retention, preceptor/licensing supervision, workforce development and training, as well as other integrated health team support services.

Total A1 funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $3,271,373.22

- CY 17 (July – December 2017): $770,081.59
- CY 18 (January – December 2018): $1,075,708.33
- CY 19 (January – December 2019): $743,349.04
- CY 20 (January – December 2020): $682,234.36

Total funding expended to date (July 2017 – June 2019): $1,218,056.90

- CY 17 (July 2017 – December 2017): $46,922.00
- CY 18 (January 2018 – December 2018): $622,934.00
- CY 19 (January 2019 – June 2019): $548,201

Projections are displayed for the July to December 2019, as well as CY 2020 and 2021 (January to June) in the Workforce Capacity Building Budget Table (A1-6a) at the end of this section. Below is more detail to support those budgets.

Approved funding allocations/projections

A1 project strategy funding allocations with projections by funding line item were made to numerous IDN Member Entity provider partners within line items shown below

Workforce recruitment/hiring and retention/sustainability:

- Incentives to support advertising/recruitment company fees; as well as sign-on, referral and retention bonuses; relocation expense reimbursement; student loan repayment; and employee recognition (Greater Nashua Mental Health, Harbor Homes, Keystone Hall, Healthy at Home, Lamprey Health, Southern NH Health).
- Staff supervision stipends to build workforce capacity, including MLADCs (up to 13.5 LADCs) and other licensed clinical roles (up to 11 Master's level clinicians and 1 Physician Assistant for certification) (Greater Nashua Mental Health, Harbor Homes, Keystone Hall, Lamprey Health, Southern NH Health, The Youth Council).
- Intern/preceptor stipends for Master's level intern cohort (up to 6 FTEs Behavioral Health Clinicians/Specialists) to build workforce for youth/adolescents and adult clinicians (Greater Nashua Mental Health and The Youth Council)

Workforce education and knowledge capacity building:

- Professional development CEUs/CMEs as well as license fees/professional association fees/dues (Greater Nashua Mental Health, Harbor Homes, Keystone Hall, Lamprey Health, Southern NH Health).
- Staff education and training for multi-disciplinary core team members and non-direct care staff, as well as IDN provider organization staff professional development for partners (Ascentria Care Alliance, Gateways Community Services, Greater Nashua Mental Health, Harbor Homes, Healthy at Home, Keystone Hall, Lamprey Health, NAMI NH, The Emmaus Institute, The Youth Council, as well as other contracted outside vendors providing individual IDN trainings).

Consultants providing technical assistance, training and other services to support IDN strategies:

- Critical Time Intervention (CTI) strategy education and technical assistance to meet program fidelity ([redacted] via North Country Consortium).
- Integrated Dual Diagnosis Treatment (IDDT) strategy education and technical assistance to meet program fidelity (Case Western Reserve University).
- Practice Site Self-Assessments (SSAs) provided bi-annually to all IDN Member Entity practices/organizations engaged in moving toward Coordinated Care Practice and Integrated Care Practice designation (University of NH Citizens Health Initiative).
- Support for referral pathways for positive screens/assessments (Granite United Way).
- Complete an analysis of comparable mental health non-profit organizations regarding compensation/incentive packages and provide suggestions for how to attract and retain staff (Greater Nashua Mental Health).
- Provide improvements to agency's webpage to create a more integrated online application process to streamline process for both applicants and HR (Greater Nashua Mental Health).

Enhanced/expanded staffing and services, including the following expenses: employee salary/wages and benefits; equipment; supplies; travel/parking; occupancy; telephone; occupancy; postage; printing/copying; audit/legal; insurance; software; marketing/communication; sub-contracts/agreements) to support the IDN 3 integrated health strategies:

- Master's level counselors (2 FTEs Behavioral Health Clinician/Specialist) to work with Nashua Middle Schools to conduct screening, brief intervention and referrals to higher levels of treatment (The Youth Council).
- Community Health Worker (1 FTE) to support care coordination for new immigrants and refugees (Ascentria Care Alliance).
- Training Coordinator (.5 FTEs) to support Cultural Competency and Adaptation training for IDN partners and the healthcare pipeline (Ascentria Care Alliance).
- DSRIP Integration Project Managers (2 FTEs) to support the IDN Admin Lead roles and responsibilities (Southern NH Medical Center).
- Family Education/Peer Support Specialist (1 FTE) to support families of youth (up to age
- 26) with SMI/SPMI (NAMI NH)
- Licensed Therapists (.78 FTEs Licensed Pastoral Psychotherapists) and Administrative Assistant (.25 FTEs) to support:
    - Pastoral Care Specialist training for faith leaders (The Emmaus Institute).
    - Spirituality in Patient Care training for providers (The Emmaus Institute).
    - Bridges of Hope/behavioral health disorders education for faith community and congregations (The Emmaus Institute and NAMI NH).
    - Enhanced individual spirituality therapy/clinical services, including implementation of CCSA and universal screening (The Emmaus Institute).

- Community Health Workers (5 FTEs) trained to support care coordination and education through Dartmouth Hitchcock Americorps VISTA Community Resource Corps (City of Nashua Department of Public Health, Greater Nashua Mental Health, Harbor Homes, Southern NH Medical Center, St. Joseph Hospital and Physician Practices).
- Clinical case management for clients with intellectual/developmental disabilities (monthly stipend) with Gateways Community Services.

Indirect Costs:

- Capped at 15% per the IDN 3 Finance Governance Committee for all IDN Member Entity sub-contracts

*The providers/positions funded in the A1 budget do not reflect all providers/positions identified in the A1-5 Staffing Targets. See A2-5, B1-4, C-3, D-3 and E-3 for other providers/positions funded in those respective project budgets.

Funding expenditures during reporting period

The IDN implements a reimbursement only model for all funding allocations following the state fiscal year (SFY) sub-contract time frame (July – June). For the expenditures reflected in the narrative and budget table below, some of the services were provided during the previous reporting period (July – December 2018) and some invoices have been received, but not fully processed and reflected in the outlined for the current reporting period.

Workforce recruitment/hiring and retention/sustainability:

- Greater Nashua Mental Health Center:
  - Staff referral bonuses: 4 staff
  - Recruitment ads/fees: multiple behavioral health positions
  - Staff recognition: more than 7 staff
  - Sign-on bonuses: 7 staff
  - Stay incentives/retention bonuses: 3 staff
  - Supervision stipends:
    - 8 LADCs moving toward MLADC
    - 8 Master's level clinicians moving toward LICSW/LCMHC
  - Master's level intern cohort stipends: 1 staff
- Lamprey Health:
  - Supervision stipend to support certification for a Physician Assistant
- The Youth Council:
  - Master's level intern cohort stipends: 1 staff
  - Supervision stipends: 3 non-LADCs
  - Student loan repayment: 3 Behavioral Health Clinicians/Specialists

Workforce education and knowledge capacity building:

- License fees/ dues
  - Greater Nashua Mental Health: 10 staff
  - Lamprey Health: 1 staff
- CMEs/professional development
  - Ascentria Care Alliance: 2 staff
  - Lamprey Health: 2 staff (4 courses), plus lost productivity time
  - NAMI NH: 1 staff
  - The Emmaus Institute (for 1 staff)

- The Youth Council: 2 staff

Staff education and training:

- Situational Leadership training and coaching: GNMH (30 staff and 7 administrators)
- Clinical Foundations Training Series: Gateways Community Services (10 staff)
- Adult Mental Health First Aid:
  - provided by GNMH on June 13th (16 participants)
  - provided by NAMI NH on May 22nd for Home Health and Hospice Care (34 staff)
  - provided by GNMH on March 25th (19 participants)
- Youth Mental Health First Aid: provided by NAMI NH with YMCA camp counselors (22 staff)
- Differential Diagnosis: Assessing Mental Health and Substance Use Disorders training (MLADC candidate attended at New England School of Addiction and Prevention Studies with IDN funding support)
- Chronic Disease Training for Behavioral Health Providers on March 6th (15 participants)
- Advanced Training on Co-Occurring Disorders and Recovery: 2 part series January 24 – 26th (7 participants)
- Basic Motivational Interviewing January 25th (4 participants)

Consultants:

- [redacted]
  - Critical Time Intervention (CTI) training, technical assistance and Community of Practice facilitation
- [redacted]
  - hired by GNMH to support completion of a compensation analysis to increase understanding about salary ranges to *allow staff to grow within their agency rather than to view the CMHC as a training ground to leave once obtaining experience*. This consultant provided an analysis of comparable organizations re: compensation/incentive packages and provide suggestions for how to attract and retain staff.
- [redacted]
  - Hired by GNMH to provide improvements to their webpage to *create a more integrated online application structure to streamline the hiring process for both applicants and human resources*.

Enhanced/expanded staffing and services to support the IDN 3 integrated health care, including employee salary/wages and benefits, equipment, travel, occupancy, current expenses, marketing/communications, staff education/training, client services (including interpretation services), and indirect costs (capped at 15%, per the IDN Finance Committee cap):

- The Youth Council: Master's level counselors (2 FTEs)
- Ascentria Care Alliance: Community Health Worker (1 FTE) and Cultural Education Trainer (.5 FTEs)
- Southern NH Medical Center: DSRIP Integration Project Managers (2 FTEs)
- NAMI NH: Family Education/Peer Support Specialist (1 FTE)
- The Emmaus Institute: Licensed Therapists (.78 FTEs Licensed Pastoral Psychotherapists) and Administrative Assistant (.25 FTEs)

Other (indirect costs, capped at 15% per IDN Finance Committee):

- Ascentria Care Alliance
- Greater Nashua Mental Health
- Lamprey Health
- NAMI NH

- The Emmaus Institute
- The Youth Council

For the remaining years of the DSRIP demonstration, projected funding allocations are broken down equally across 24 months (through June 2021), with the expectation that as we move into the coming months, we will become more certain of how the funding needs will change for our partners to meet the DSRIP performance outcome measures.

A1-6a IDN Level Workforce: Building Capacity Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan - June 2019 Actuals	July - Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	$2,430,730	$0	$24,266	$370,405	$332,749	$425,827	$851,655	$425,827	$2,430,730
Employee Benefits	$30,171	$0	$0	$14,700	$15,471	$0	$0	$0	$30,171
Consultants	$452,232	$0	$0	$50,325	$51,900	$87,502	$175,003	$87,502	$452,232
Equipment	$8,063	$0	$3,385	$3,135	$1,543	$0	$0	$0	$8,063
Supplies (sum of lines below)	$33,860	$0	$8,553	$19,285	$6,022	$0	$0	$0	$33,860
Educational	$0	$0	$0	$0	$5,334	$0	$0	$0	$5,334
Medical/Lab/Pharmacy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Office	$25,717	$0	$8,553	$19,285	$688	$0	$0	$0	$28,526
Travel (mileage/parking expenses)	$17,737	$0	$270	$7,674	$9,793	$0	$0	$0	$17,737
Occupancy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Current Expenses (sum of lines below)	$12,903	$0	$838	$5,043	$7,022	$0	$0	$0	$12,903
Telephone	$0	$0	$838	$2,448	$2,086	$0	$0	$0	$5,372
Internet costs	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postage	$0	$0	$0	$0	$174	$0	$0	$0	$174
Printing and Copying	$0	$0	$0	$2,229	$3,313	$0	$0	$0	$5,542
Audit and Legal	$0	$0	$0	$0	$1,100	$0	$0	$0	$1,100
Insurance	$0	$0	$0	$365	$349	$0	$0	$0	$714
Board Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Software	$0	$0	$0	$0	$0	$0	$0	$0	$0
Marketing/Communications	$3,122	$0	$0	$3,122	$0	$0	$0	$0	$3,122
Staff Education and Training	$125,538	$0	$9,610	$68,445	$47,483	$0	$0	$0	$125,538
Subcontracts/Agreements	$20,477	$0	$0	$13,244	$7,233	$0	$0	$0	$20,477
Other (specific details mandatory):	$69,326	$0	$0	$37,095	$32,231	$0	$0	$0	$69,326
Recruitment Fees	$0	$0	$0	$16,027	$3,385	$0	$0	$0	$19,412
Sign-on Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Referral Bonuses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Relocation Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Student Loan Repayment/Reimbursement	$0	$0	$0	$0	$5,000	$0	$0	$0	$5,000
Employee Recognition/Retention Bonus	$0	$0	$0	$2,571	$23,846	$0	$0	$0	$26,417
CMEs/Professional Development	$0	$0	$0	$0	$0	$0	$0	$0	$0
Professional Development Fees/Dues	$0	$0	$0	$18,498	$0	$0	$0	$0	$18,498
Staff Licensing/Certification Supervision Stipend	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other: please specify below	$67,216	$0	$0	$30,462	$36,754	$0	$0	$0	$67,216
TOTAL	**$3,271,373**	**$0**	**$46,922**	**$622,934**	**$548,201**	**$513,329**	**$1,026,658**	**$513,329**	**$3,271,373**

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

Changes to partner engagement:

LaMora Psychological Associates submitted an IDN withdrawal letter based on concerns with the data reporting requirements as they relate to "various state regulations and ethical concerns." The IDN has submitted this letter to DHHS and is awaiting DHHS review/comment.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
American Medical Response (AMR)	Other Organization Type	A2
Ascentria Care Alliance	Community-Based Organization Providing Social and Support Services	A1, A2
Bridges Domestic and Sexual Violence Support	Community-Based Organization Providing Social and Support Services	A2
City of Nashua Department of Public Health	Public Health Organization	A1, A2
Courville Communities	Nursing Facility	A2
Crotched Mountain	Other Organization Type	A2
Dartmouth Hitchcock (DH)		
DH Nashua Family Medicine	Primary and Specialty Care Practices	A2, B1
DH Nashua Internal Medicine	Primary and Specialty Care Practices	A2, B1
DH Hudson	Primary and Specialty Care Practices	A2, B1
DH Merrimack	Primary and Specialty Care Practices	A2, B1
DH Milford	Primary and Specialty Care Practices	A2, B1
DH Nashua Pediatrics	Primary and Specialty Care Practices	A2, B1
Foundation Medical Partners (FMP)		
FMP: Amherst Family Practice	Primary and Specialty Care Practices	A1, A2, B1
FMP: Downtown Medical Associates	Primary and Specialty Care Practices	A1, A2, B1
FMP: Hudson Family Practice	Primary and Specialty Care Practices	A1, A2, B1
FMP: Milford Family Practice	Primary and Specialty Care Practices	A1, A2, B1
FMP: South Nashua Family Practice	Primary and Specialty Care Practices	A1, A2, B1
FMP: Internal Medicine Associates of Nashua	Primary and Specialty Care Practices	A1, A2, B1
FMP: Merrimack Medical Center	Primary and Specialty Care Practices	A1, A2, B1
FMP: Nashua Primary Care	Primary and Specialty Care Practices	A1, A2, B1

FMP: Nashua West Adult Medicine	Primary and Specialty Care Practices	A1, A2, B1
FMP: Pelham Family Medicine	Primary and Specialty Care Practices	A1, A2, B1
FMP: Internal Medicine at Pelham Medical Center	Primary and Specialty Care Practices	A1, A2, B1
FMP: Medicine-Pediatrics of Nashua	Primary and Specialty Care Practices	A1, A2, B1
FMP: Foundation Pediatrics	Primary and Specialty Care Practices	A1, A2, B1
FMP: Main Street Pediatrics and Adolescent Medicine	Primary and Specialty Care Practices	A1, A2, B1
FMP: Internal Medicine	Primary and Specialty Care Practices	A1, A2, B1
Front Door Agency	Community-Based Organization Providing Social and Support Services	A2
Gateways Community Services	Area Agency	A1, A2
Granite State Independent Living (GSIL)	Community-Based Organization Providing Social and Support Services	A2
Greater Nashua Mental Health Center	Community Mental Health Center and Substance Use Treatment Provider	A1, A2, B1, C1, D3, E4
H.E.A.R.T.S. Peer Support Center	Peer Support and Respite Care	A2, D3
Harbor Homes	Federally Qualified Health Center	A1, A2, B1, D3
Healthy at Home	Community-Based Organization	A1, A2
Hillsborough County Nursing Home and Corrections	County Nursing and Jail Facility	A2
Home Health and Hospice	Community-Based Organization Providing Social and Support Services	A2
Keystone Hall	Federally Qualified Health Center and Substance Use Treatment Provider	A1, A2, B1, D3
~~LaMora Psychological Associates~~	~~Behavioral Health Provider~~	~~A2, B1~~
Lamprey Health	Federally Qualified Health Center	A1, A2, B1
Life Coping	Other Organization Type	A2
Merrimack River Medical Services	Substance Use Treatment Provider	A2, B1
NAMI NH	Community-Based Organization Providing Social and Support Service	A1, A2
Revive Recovery Support Center	Peer Support	A2
Southern NH Medical Center	Acute Care Hospital Emergency Department, Surgical Center, Inpatient Hospitalization and Substance Use Treatment Provider	A1, A2, B1, D3
Southern NH Services	Community-Based Organization Providing Social and Support Service	A2
St. Joseph Community Services	Community-Based Organization Providing Social and Support Service	A2

St. Joseph Hospital	Acute Care Hospital Emergency Department, Surgical Center	A1, A2, B1, D3
St. Joseph Hospital & Physician Practices (SJH)		
SJH Pediatrics Nashua	Primary and Specialty Care Practices	A2, B1
SJH Pediatrics Milford	Primary and Specialty Care Practices	A2, B1
SJH Pediatrics Sky Meadow	Primary and Specialty Care Practices	A2, B1
SJH Family Medicine, Nashua	Primary and Specialty Care Practices	A2, B1
SJH Internal Medicine	Primary and Specialty Care Practices	A2, B1
SJH Family Medicine and Specialty Services Hudson	Primary and Specialty Care Practices	A2, B1
SJH Family Medicine and Specialty Services Merrimack	Primary and Specialty Care Practices	A2, B1
SJH Family Medicine and Specialty Services Milford	Primary and Specialty Care Practices	A2, B1
SJH Adult Medicine	Primary and Specialty Care Practices	A2, B1
The Emmaus Institute	Mental Health and Substance Use Treatment Provider	A1, A2, B1, D3
The Youth Council	Substance Use Treatment Provider	A1, A2, B1, D3
YMCA of Greater Nashua	Community-Based Organization Providing Social and Support Service	A2
United Way of Greater Nashua	Community-Based Organization Providing Social and Support Service	A2

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				
A1-4	Evaluation Project Targets	Table				
A1-5	IDN-level Workforce Staffing Targets	Table				
A1-6	IDN-level Workforce Capacity Budget	Narrative and Spreadsheet				
A1-7	IDN Workforce Key Organizational and Provider Participants	Table				

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

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

See attachment_A2.3a: IDN HIT/HIE Implementation Plan

The HIT implementation goals, milestones and assessment for each area are defined in the *A2-4. IDN HIT: Evaluation Project Targets* table. The IDN has made a tremendous amount of progress in securing the necessary BAA/QSOA and Data Use Agreements (DUAs) as part of the A2: HIT IDN sub-contracting process during Q1 & Q2 of 2019 but still struggle with some of our partners which has delayed 100% achievement of several of our HIT goals.

We continue to engage all of our partners in order to support their engagement with completing the IDN's minimum technology requirements. The following are some of the barriers we have encountered:

- Continued trepidation and uncertainty associated with data sharing, data security and patient confidentiality,
- Concern around the lack of resources and funding to complete required reporting and technology support
- Not having local decision making capability impacting the ability to move forward or to implement any technology changes.

However, there was some significant progress made during this reporting period as the IDN has taken the following mitigation steps to address some of the above concerns:

- The partner liaisons for each of our partners as well as HIT specific liaison continue to help guide, educate and answer any questions and concerns by meeting monthly or as needed basis with our partners to assist in moving forward with the minimum HIT technologies.
- With the use of the [redacted] tool, partner liaisons continue to use detailed partner specific work plans and HIT Partner Status to track progress towards HIT milestones and to work closely with our partners on all aspects of their IDN projects.
- The IDN provided education and training on all of the minimum required HIT platforms through
  - Inviting our vendors to provide overviews and to address vendor specific questions at Governance Committee Meetings, Full IDN Meetings as well as at individual partner level
  - Bi-weekly or monthly meetings with vendor to assess progress, address concerns/issues and schedule any partner specific trainings as requested
  - The HIT partner liaison works closely with each partner to further education via the bi-weekly and other scheduled calls around specific topics and set up structure around getting and providing status updates, feedbacks/questions/concerns
- The Data/IT Committee meeting focus has migrated from vendor platform identification & implementation to partner progress, reporting and data analytics
- The IDN is providing monthly reporting of dashboards with partner status in hitting all the required HIT minimum technologies, [redacted] outcome data, as well as platform usage data to our partners and to our various Governance Committees; this allows the entire IDN to review current A2 status and impact on funding.

Partner Engagement Overview

With that in mind, our partners fall into the following 4 categories in regards to A2 technology advancement, which will be echoed throughout this document for the various technology categories:

1. Those who have signed A2 sub-contracting and are fully participating and have completed all of their minimum HIT requirements
2. Those who have signed A2 sub-contracting who are engaged and are in the process of completing all of their minimum HIT requirements – most of our partners fall into this category
3. Those who have signed A2 sub-contracting but have not been engaged or unable to engage due to internal barriers;
4. Those who still have **not** signed sub-contracting – they fall into two categories
   a. Those who have higher impact to multiple IDN projects
   b. Those who are support services to IDN projects but still impact ability to meet A2 deliverables:

In the project plan and A2-4. IDN HIT: Evaluation Project Targets table, we had included all of our IDN partners to have the capabilities of all of the HIT Minimum Standards defined in the New Hampshire Health Information Technology Standards Report document. We are including these partners in the A2 section of the SAR for this reporting period but, in the next months, we will determine which capabilities based on IDN related workflows, make sense for these partners.

IDN 3 Partner Engagement Overview
As of 6.30.19

Category	Partner Participation
1. Have signed A2 sub-contracting & are fully engaged	• Crotched Mountain • Greater Nashua Mental Health Lamprey • Home Health and Hospice Care • Lamprey Health • Southern NH Medical Center • The Youth Council
2. Have signed A2 sub-contracting & are engaged but have some open items	• Ascentria Care Alliance • City of Nashua Department of Public Health • Dartmouth Hitchcock (6 Practices) • Foundation Medical Partners (15 Practices) • Gateways Community Services • Granite State Independent Living (GSIL) • H.E.A.R.T.S. Peer Support Center • Life Coping • NAMI NH • The Emmaus Institute
3. Have signed A2 sub-contracting but has not been engaged	• St. Joseph Hospital • St. Joseph Hospital and Physician Practices (9 Practices) • Revive Recovery Support Center
4a. Have not signed A2 sub-contracting – High impact to multiple IDN projects	• Partnership for Successful Living (Harbor Homes and Keystone Hall) • Merrimack River Medical Services
4b. Have **not** signed A2 sub-contracting – social services to be reconsidered for next evaluation	• American Medical Response (AMR) • Bridges Domestic and Sexual Violence Support • Front Door Agency • Southern NH Services

	• St. Joseph Community Services • YMCA of Greater Nashua • United Way of Greater Nashua

The following partner engagement change is reflected in the A2-7. IDN HIT: Key Organizational and Provider Participants table and is being removed from "met" criteria assessment:

- LaMora Psychological Associates: submitted an IDN withdrawal letter based on concerns with the data reporting requirements as they relate to "various state regulations and ethical concerns"; awaiting DHHS review/comment

Minimum HIT Capabilities/Standards

Data Extraction and Validation

The IDN has continued to support our B1 partners in both data reporting and quality analysis. The IDN regularly participates in partner specific bi-weekly calls with [redacted] as well as meeting directly with partners as needed to answer questions or to work through operationalization of workflows to support the measurements. Some of our partners have already achieved a regular monthly cadence on their reporting; others have completed their calendar year reporting commitments and are working towards a monthly reporting cadence for all of their data.

Most of our partners have also engaged in internal quality reviews with both the report writers and the IDN lead clinical or quality representative prior to initial delivery of files to [redacted] In Q2 of 2019, the IDN has begun providing monthly reporting of [redacted] outcome data to our partners and to our various Governance Committees

NOTE: Harbor Homes and Keystone are combined historically for this category into Partnership for Successful Living and St Joseph Hospital and St. Joseph Primary Care Network are also combined to keep consistent with 8 partners as reported in the Jun. – Dec. 2018 SAR for this category.

Progress:

- Electronic Submission: 5 out of 8* partners with EHRs are regularly providing electronic production data to [redacted]
- Manual Submission: 2 out of 2 partners submitting data manually into [redacted]

Barriers/Challenges and Mitigation Plans:

The 3 who have not achieved this goal have either not completed their sub-contracting process or have not been able to provide data to [redacted] due to internal barriers. We continued to work with these partners in 2019 and are hopeful they will participate in FY2020. Below is more detail about the barriers/challenges and IDN mitigation plans.

St. Joseph Hospital and Physician Practices (SJH)

Issues: Due to lack of resources, St. Joseph Hospital and Physician Practices have not been able to provide extract files for either the CY2018 (due June 19th) and so far have been unable to submit monthly data files for the Jan – Jun 2019 six month measures (which are due August 15th). The allocated data/IT reporting resource was consistently pulled by their executive management for other internal tasks, thus unable to move forward to complete the data extraction requirements.

Mitigation plan: The IDN met bi-weekly with [redacted] SJH's report writer and quality representative throughout the reporting period to review measure requirements, discuss progress, barriers and mitigation plans. The focus for the Jan-Jun 2019 reporting period was to complete the CY2018 calendar year measures for the 06/15/19 deadline, with the IDN lead to continue to reach out to STJ lead throughout the reporting period to discuss issues/concerns and provide mitigation alternatives. As of the end of the reporting period, SJH has decided that they may be able to manually support the CY2018 outcome measures via chart extractions when the BH sub-population is available from DHHS. The IDN is working with SJH's management to determine if we can provide any additional external resources support to achieve this milestone.

Partnership for Successful Living (Harbor Homes and Keystone Hall)

Issues: They have not been able to provide extract files for either the CY2018 or the six month measures due to the lack of IDN sub-contracting execution.

Mitigation plan: The IDN has worked closely with Partnership to re-evaluate their Statement of Work. Partnership has re-engaged in Q2 of 2019 and has received approval from Clinical, Finance and Executive Committees. They have re-engaged in Q2 of 2019 and expressed a lot of interest in moving forward with the IDN, so we are hopeful they will complete the IDN sub-contracting process by September 2019 to successfully meet key reporting deliverables.

Merrimack River Medical Services (MRMS)

Issues: They have not been able to provide extract files for either the CY2018 or the six month measures due to the lack of IDN sub-contracting execution.

Mitigation strategies: The IDN will continue to engage with Merrimack River Medical Services, as we have received great interest in their participation. We are hopeful they will complete the IDN sub-contracting process by September 2019 to successfully meet key reporting deliverables.

Partner Status on Monthly [redacted] Reporting
As of 6.30.19

Practice Name	2018 Jan. – Dec. Calendar Year Measures Initial Feed	2019 Jan. – Jun. 6 Month Measures Monthly/Manual Feed
	Due 06/15/19	Due 08/15/19
Dartmouth Hitchcock Clinic – Nashua	✓	✓
Foundation Medical Partners	✓	✓
Greater Nashua Mental Health	N/A	✓
Lamprey Nashua (InteGreat Health)	✓	✓
Southern NH Medical Center	✓	N/A
St. Joseph Hospital and Primary Care Network	×	×
The Emmaus Institute	N/A	✓ (Manual)

The Youth Council	N/A	✓ (Manual)
Merrimack River Medical Services	N/A	✖
Partnership for Successful Living (Harbor Homes, Keystone Hall)	✖	✖

Internet Connectivity

All IDN Member provider entities who store or capture Protected Health Information (PHI) for IDN attributed patients must have a secure Internet connection. Based upon our initial HIT assessment, we identified one provider partner (The Emmaus Institute) who needing to utilize IDN funding allocations to support a business grade Internet router and applicable monthly fees associated with secure Internet vendors.

Secure Data Storage

Funding has been allocated to the IDN Member provider entities to support the completion of a cybersecurity assessment to ensure compliance with NIST capabilities which is a minimum capability/standard for the IDN and will be required for those providers who store and/or capture Protected Health Information (PHI) for IDN attributed patients or those who will interact with the shared care plan process. Our partners can either choose to contract with our IDN-approved vendor (e.g., [redacted] to achieve this capability/standard or if they already completed an assessment as part of their EHR certification or with another vender, they can provide the IDN with an attestation and invoicing documentation as part of their request for reimbursement of the costs associated with the assessment.

For some of our smaller partners who do not have a high level of electronic presence, the IT/Data Committee co-chairs concluded that a HIPAA Risk Assessment with a maturity score or a HITECH ASSESSMENT with a maturity score was acceptable and made sense for those partners. In Q2 of 2019, the IDN started offering this option to our partners who, with consultation with our IDN-approved vendor (e.g., [redacted] have determined which is the best assessment for their organization.

Progress:

Out of 32 organizations listed in table A2-7. IDN HIT: Key Organizational and Provider Participants, 21 have met their Cybersecurity Assessment requirement or are currently in progress. There are several partners who are included in this count who are in the A2 non-subcontracted category that we know have EHRs and have this inherent capability and expect to have confirmation of an assessment being completed as part of their EHR certification once they complete sub-contracting. These partners are: Harbor Homes, Hillsborough County Nursing Home and Corrections, Keystone Hall, Merrimack River Medical Services, St. Joseph Hospital and Physician Practices and marked with an asterisk (*) in the below table

Barriers/Challenges and Mitigation Plans:

Out of 32 organizations listed in table A2-7. IDN HIT: Key Organizational and Provider Participants, 11 have not met their Cybersecurity Assessment requirement to date.

- For those partners who are Category 3 or 4.a. as defined in "Partner Engagement Overview" section above, we are working closely with them to remove any barriers they have identified in moving forward or closing on their next steps.
- For those partners who are Category 4.b. as defined in "Partner Engagement Overview" section above, we will meet to review their status and to determine which capabilities make sense for

these partners.

Partner Status on Achievement of Secure Data Storage
As of 6.30.19

Status Category	Partner
Completed	• Ascentria Care Alliance • Crotched Mountain • Dartmouth Hitchcock (DH – 6 Practices) • Foundation Medical Partners (FMP – 15 Practices) • Granite State Independent Living (GSIL) • Greater Nashua Mental Health (GNMH) • Harbor Homes* - has EHR • Hillsborough County Nursing Home and Corrections* • Home Health and Hospice Care (HHH) • Lamprey Health • Keystone Hall* - has EHR – being brought under Harbor Homes EHR • Life Coping • Merrimack River Medical Services* - has EHR • NAMI NH • St. Joseph Hospital* • St. Joseph Hospital and Physician Practices (9 Practices)* • Southern NH Medical Center • The Emmaus Institute • The Youth Council
In Progress: Scheduled and expect to complete in July 2019	• H.E.A.R.T.S. Peer Support Center – HIPAA assessment scheduled for mid-July • Revive Recovery Support Center - – HIPAA assessment scheduled for early July
Not Started: Signed A2 sub-contracting but not started for various reasons	• City of Nashua Department of Public Health – Sub-contracting with [redacted] needs completion as next step; expect to be completed in July of 2019 • Gateways Community Services – recently signed A2 contract; sub-contracting with [redacted] need completion as next step; expect to be completed in July of 2019
Not Started: A2 sub-contracting not completed in order to engage with IDN approved vendor	• American Medical Response (AMR) • Bridges Domestic and Sexual Violence Support • Courville Communities • Front Door Agency • Healthy at Home • Southern NH Services • St. Joseph Community Services • YMCA of Greater Nashua • United Way of Greater Nashua

<u>Shared Care Plan (SCP), Event Notification Service (ENS) Receipt</u>

Progress:

All IDN Member providers are working toward Coordinated Care Practice designation and have the ability

to access and/or contribute to an electronic Shared Care Plan (SCP) and receive ADTs (admissions, discharges and transfers) related to emergency department and inpatient visits through directly contracting with [redacted] ([redacted] once they have executed their IDN sub-contract (including the BAA/QSOA and DUA). This capability/standard will support the requirement that information is regularly shared among care team members. This information includes identification of care team members, goals, concerns and treatment plans as part of a team approach to care, as approved by the Statewide SCP Taskforce in late 2017. It is expected that care coordinators/case managers will be the primary staff to have role- based access to the SCP platform.

Out of 30 organizations who are expected to receive ENS, 6 have the ability to receive ENS, 8 are currently engaged in acquiring [redacted] for ENS and SCP and 1 does not qualify to access ENS and SCP. For the 15 partners who have not met their SCP/ENS requirement:

- Those in Category 3 or 4a. as defined in "Partner Engagement Overview" section above, we are working closely with them to remove any barriers they have identified in moving forward or closing on their next steps.
- Those in Category 4b. do not qualify for [redacted] due to not being a HIPAA covered entity & no TPO patient relationship.

Barriers/Challenges and Mitigation Plans:

Issue: Acquiring [redacted] requires going through several steps: completing the Discovery Form process, executing contract, completing the kickoff call, generation and uploading of a patient file profile and finally, the user training. We have noticed that the two steps our partners tend to stall in are the sub-contracting and patient file generation.

Mitigation plan:

- The IDN meets regularly (bi-weekly or more often as needed) with [redacted] to discuss partner status and barriers and ways to help our partners move forward.
- The IDN participates in partner specific kick off and user training calls to ensure IDN representation is available for addressing any questions/concerns; in particular, ensure partners are aware of IDN specific requirements/policies/procedures.
- The IDN provides monthly provider status updates to all partners highlighting each partner's current status in achieving this milestone.
- The IDN HIT liaison follows up and meets with partners to address any issues or concerns in sub-contracting or patient file for any of the steps in the process.

Issue: Our partners have been very interested in the event notification system the [redacted] Platform provides especially since this capability does not require additional patient consent. However, there is continued trepidation associated with data sharing, data security and patient confidentiality amongst our providers for shared care plan participation which has been a challenge.

Mitigation plan: To address these concerns, the IDN has adopted the policy of getting patient consent prior to entering any data into a shared care plan.

Issue: One of the needs of the IDN is for partners be able to report about their attributed Medicaid patients they are monitoring using [redacted] Several of our partners have chosen to include all of their patients, not just Medicaid patients, to their [redacted] patient profile. In order to do this, the IDN is requiring that partners identify all Medicaid patients in their patient file profile

Mitigation plan: The IDN has worked with [redacted] to add an identifier into the patient file template to tag Medicaid patients and to create pre-defined Medicaid specific cohorts available to our partners similar to those already available in [redacted] for all patient types.

Partner Status on Achievement of ENS/SCP
As of 6.30.19

Status Category	Partner
Completed	• Ascentria Care Alliance • Crotched Mountain • Greater Nashua Mental Health (GNMH) • Home Health and Hospice Care (HHH) • Lamprey Health • The Youth Council
In Progress: At various phases of [redacted] install process – criteria for completion is user training completion	• City of Nashua Department of Public Health – Sub-contracting with [redacted] not complete • Dartmouth Hitchcock (6 Practices) – DH Nashua patient file & access model discussions in progress between HD Corporate & [redacted] • Foundation Medical Partners (FMP – 15 Practices) - Sub-contracting with [redacted] in progress – [redacted] process expect to be completed in July • Granite State Independent Living (GSIL) – 1st patient file upload not complete • Life Coping –will have uploaded statewide IDN beneficiaries by mid-July • NAMI NH –1st patient file upload not complete • Revive Recovery Center – Sub-contracting with [redacted] not complete • The Emmaus Institute –creation of patient file in progress
Not Applicable: they do not qualify due to not being a HIPAA covered entity & no TPO patient relationship	• H.E.A.R.T.S. Peer Support Center
Not Started: various reasons	• Gateways Community Services – recently signed A2 contract; expect to complete in Q3 2019 • St. Joseph Hospital and Physician Practices (9 Practices) – unable to engage due to internal barriers
Not Started: A2 sub-contracting not completed	• American Medical Response (AMR) • Bridges Domestic and Sexual Violence Support • Courville Communities • Front Door Agency • Harbor Homes • Healthy at Home • Hillsborough County Nursing Home and Corrections • Keystone Hall • Merrimack River Medical Services • Southern NH Services • St. Joseph Community Services • YMCA of Greater Nashua • United Way of Greater Nashua

Transmit Event Notification

The two IDN3 hospitals (St. Joseph Hospital and Southern NH Medical Center) are expected to send and receive ADTs through the use of the [redacted] platform along with SCP capabilities with [redacted] ([redacted]

Progress:

Out of 2 hospitals, 1 (SNHMC) has the ability to transmit ADT's (Admission, Discharge, Transfer) for ENS, having gone "live" on 09/18/2018 with Pre-Manage ED, and has been transmitting event notifications during this reporting period. Training was provided to staff within the emergency department, as well as with the ACCESS team and ED Case Management team on 09/12/18. St. Joseph Hospital has not yet achieved this minimum capability.

Barriers/Challenges and Mitigation Plans:

Issue: SJH has not achieved this minimum capability due to technical and staffing barriers due to its recent merger with Covenant Health and migration to a new EHR.

Mitigation plan: The IDN is working with STJ's management to determine if we can provide any external support to achieve this deliverable, including reviewing IDN funding allocations to determine if any of those funds can be used to support their technical and staffing barriers.

Partner Status on Achievement of Transmitting Event Notification
As of 6.30.19

Status Category	Partner
Completed	• Southern NH Medical Center
Not Started	• St. Joseph Hospital – unable to engage due to internal barriers

Direct Secure Messaging (DSM)

All IDN Member providers have been allocated funding to support annual contracting costs associated with contracting with the IDN-approved HIT vendor [redacted] to support their ability to use the protocol Direct Secure Messaging (DSM) to transmit attributed patient information between IDN member entity providers. However, we were notified in late Q3 of 2018 that the pricing model had changed for [redacted] from what was budgeted for the entire waiver period based on NHHIO licensing which expired end of June of 2018. This was brought to the Data/IT and the Finance Governance Committees and the decision was to have an IDN sponsorship agreement with [redacted] vs the previous model where each provider sub-contracting with [redacted] directly. This was secured in Q2 of 2019 and we have now on-boarded many of the A2 sub-contracted partners who were remaining at the end of December 2018.

For those IDN Member providers with certified EHRs, they have the ability to have direct secure messaging within their EHR but we have asked them to confirm their direct ID's.

As part of enhancing this capability, the IDN is gathering all the partner DSM ID's, including those with EHR systems so that an annual directory can be published for the IDN partners to aid in partner collaboration and care coordination. As part of this activity, the IDN is working with each partner to send and receive a test message with the IDN to confirm the DSM ID the partner wants to publish. We expect to complete this activity by July 2019 end.

Progress:

Out of 32 organizations listed in table A2-7. IDN HIT: Key Organizational and Provider Participants, 21 have the ability to use DSM protocol. There are several partners included in this count who are in the non-subcontracted category that we know have EHRs and have this inherent capability. These partners are: Harbor Homes, Hillsborough County Nursing Home and Corrections, Keystone Hall, Merrimack River Medical Services, St. Joseph Hospital and Physician Practices and marked with an asterisk (*) in the below table.

Barriers/Challenges and Mitigation Plans:

Issue: Out of 32 organizations listed in table A2-7. IDN HIT: Key Organizational and Provider Participants, 11 have not met their Cybersecurity Assessment requirement

Mitigation plan:

- For those partners who are Category 3 or 4.a. as defined in "Partner Engagement Overview" section above, we are working closely with them to remove any barriers they have identified in moving forward or closing on their next steps.
- For those partners who are Category 4.b. as defined in "Partner Engagement Overview" section above, we will meet to review their status and to determine which capabilities make sense for these partners.

Partner Status on Achievement of Direct Secure Messaging (DSM)
As of 6.30.19

Status Category	Partner
Completed: Has DSM capabilities or [redacted]	• Ascentria Care Alliance • City of Nashua Department of Public Health • Crotched Mountain • Dartmouth Hitchcock (DH – 6 Practices) • Foundation Medical Partners (FMP – 15 Practices) • Granite State Independent Living (GSIL) • Greater Nashua Mental Health (GNMH) • Harbor Homes* - has EHR • H.E.A.R.T.S. Peer Support Center • Hillsborough County Nursing Home and Corrections* • Home Health and Hospice Care (HHH) • Keystone Hall* - has HER – being brought under Harbor Homes EHR • Lamprey Health • Life Coping • Merrimack River Medical Services* - has EHR • NAMI NH • Southern New Hampshire Medical Center • St. Joseph Hospital* • St. Joseph Hospital and Physician Practices (9 Practices)* • The Emmaus Institute • The Youth Council
Not Started: Signed A2 sub-contracting but not started for various reasons	• Revive Recovery Center – Need to complete on-boarding material • Gateways Community Services – recently signed A2 contract; expect to complete [redacted] on-boarding in July 2019 based conversation and

	clarification received from DHHS which they were seeking before moving forward.
Not Started: A2 sub-contracting not completed in order to participate in IDN [redacted] sponsorship	• American Medical Response (AMR) • Bridges Domestic and Sexual Violence Support • Courville Communities • Front Door Agency • Healthy at Home • Southern NH Services • St. Joseph Community Services • YMCA of Greater Nashua • United Way of Greater Nashua

Desired HIT Capabilities/Standards

Integrated Direct Secure Messaging (DSM)

For those IDN Member providers with certified EHRs, they should have the ability to support integrated direct secure messaging within their EHR. However, the ability to send and receive PHI externally among the IDN Member providers' needs to be demonstrated, per the IDN Data/IT Governance Committee.

Progress:

To document this ability, the IDN has started been testing their ability to send and receive PHI. Through this validation process, our partners are identifying and addressing small issues in order to completely operationalize this process. Once this testing is complete, the IDN intends to publish annually, a directory of partner DSM IDs (both [redacted] IDs and Integrated DSM IDs). This should help to facilitate usage and operationalization of this capability and less usage of technology like Faxing.

Partner Status on Achievement of Integrated DSM
As of 6.30.19

Status Category	Partner
Completed: Has demonstrated Integrated DSM capabilities	• Dartmouth Hitchcock (DH – 6 Practices) • Foundation Medical Partners (FMP – 15 Practices) • Lamprey Health • Southern New Hampshire Medical Center
Not Completed	• Greater Nashua Mental Health (GNMH) • Harbor Homes • Keystone Hall • Hillsborough County Nursing Home and Corrections • Merrimack River Medical Services • St. Joseph Hospital • St. Joseph Hospital and Physician Practices

Query-based Exchange

Up to 6 of the IDN Member providers shall have the ability to meet the desired capability/standard of query-based exchange to allow for inter-vendor capabilities to share, query and retrieve data for IDN attributed patients. One-time funding allocations are available for those partners with EHRs. While no providers submitted invoices and documentation to request access to this allocation to support Commonwell or CareEquality, we are aware that some of the IDN partners have already begun the process of securing this ability, including:

- SNHMC executed a contract with Commonwell in March and has been working with its EHR vendor to finalize interfaces. Training is being planned for workflows and protocols with applicable staff by December 2018, following the IDN protocols and guidelines. They are also migrating to EPIC which has its own built-in query-based exchange system.
- Dartmouth Hitchcock uses EPIC as its EHR, so it has its own built-in query-based exchange system.

Partner Status on Achievement of Query/Response CCDA Exchange
As of 6.30.19

Status Category	Partner
Completed: Has contracted with CommonWell/CareQuality	• Foundation Medical Partners • Dartmouth Hitchcock
Not Completed	• Greater Nashua Mental Health (GNMH) • Harbor Homes • Lamprey Health • St. Joseph Hospital and Physician Practices

Optional HIT Capabilities/Standards

Closed Loop e-Referrals

From a technology perspective, at this time, there is no comprehensive or standardized Closed Loop Referral technology in place. In Q4 of 2018, the IDN was informed about [redacted]s plans to incorporating this capability into their existing product and this capability was expected in Q2 of 2019. This was very appealing to us since we expected most of our partners to have this platform already thus, would not require introduction of another vendor/platform. However, this feature has not been made available as expected. The IDN, along with the co-chair of the Data/IT Governance Committee has recently started looking at other vendors and has been participating in evaluating two vendors being considered for several statewide initiatives: Open Beds and Unite Us. The Data/IT Co-Chair presented his thoughts to the Data/IT Governance Committee. The preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible. Therefore, until these discussions are complete, the IDN is working with our partners to document their current workflows and to see how we can leverage the current platforms available to us to achieve closed loop process as defined in the IDN 3 Closed Loop Protocols and Guidelines.

Secure Texting

Lamprey Health is working with the IDN to investigate securing IDN funding to enable secure texting capabilities between GNMHC & Lamprey for the InteGreat project. The Data/IT Governance Committee will make a recommendation to Finance Governance Committee for this to proceed in Q3 2019.

No further changes or updates in this reporting period for the following areas:

- Data Analysis/Validation
- Population Health Tools
- Capacity Management Tools
- Patient Engagement Technology

Technology Trainings Offered

The IDN has been working with its contracted HIT vendors as well as its Member providers to ensure applicable training has been provided to support operationalization of some of the HIT capabilities/standards. The table below outlines the trainings and completion by partner.

Enabling Technology Training			
Category	**Training**	**Participating Organization**	**Held**
[redacted]	[redacted] Demo/Intro Call	• Foundation Medical Partners	• 2/21/19
	[redacted] Kickoff Training	• The Youth Council • Lamprey Health • NAMI NH • Granite State Independ Living • Ascentria • Home Health Hospice	• 1/10/19 • 4/08/19 • 4/16/19 • 4/29/19 • 5/31/19 • 6/19/19
	[redacted] User Training	• The Youth Council • Lamprey Health	• 2/15/19 • 5/02/19
[redacted] Manual Entry Portal Training	Provider partner level "how-to" use and operationalize [redacted] manual entry	• The Emmaus Institute	• 6/19/19
[redacted]	[redacted] Intro Call	• Gateways	• 4/15/19
	Admin Training	• Ascentria • Dept of Public Health • Lamprey Health • Life Coping • The Emmaus Institute • The Youth Council	• 5/23/19
	User Training	• Lamprey Health • The Youth Council	• 6/4/19
	User Training	• Ascentria • Granite State Independ Living • Greater Nashua Mental Health • H.E.A.R.T.S. • NAMI NH • The Emmaus Institute	• 6/25/19

A2-4. IDN HIT: Evaluation Project Targets

The IDN has made tremendous progress on HIT evaluation targets, however, unable to achieved 100% in several categories due to the following challenges which have been themes throughout this document:

Sub-contracting, including BAA/QSOA and Data Use Agreement (DUA)

We continue to work with two of the B1 partners, *Partnership for Successful Living (Harbor Homes, Keystone Hall)* and *Merrimack River Medical Services* who have not signed BAA/QSOA and Data Use Agreements (DUAs) with the IDN by reworking their Statement of Work and budgeting for FY2020. These are being worked through our Clinical, Finance and Executive Governance Committees for approval.

We have engaged and will continue to engage the support service organizations who have yet executed sub-contracting with the IDN and will determine in the next months, which capabilities based on IDN focus, make sense for these partners and work with DHHS to make adjustments where possible.

Completion of Outcome Measures reporting to [redacted]

All of our partners who have executed BAA/QSOA and DUA have achieved this milestone except *of St. Joseph Hospital and Primary Care Network* who have faced several internal resource and time barriers. The IDN is working closely to see if they are able to achieve this milestone in a different way.

We continue to work with the other two partners, *Partnership for Successful Living (Harbor Homes, Keystone Hall)* and *Merrimack River Medical Services,* in completion of their IDN 3 sub-contracting so that they can complete this milestone.

Completion of implementation of other required minimum HIT Platforms

For those partners who have executed sub-contracting with the IDN, our focus this reporting period continued to be engaging with them to complete implementation of their required minimum HIT platforms to achieve target goals. To support these efforts, we have:

- provided monthly partner status updates to both partners and Governance Committees,
- presented dashboards and detailed partner status as well as educated our partners on our target milestones as we moved to a pay for performance model at our monthly full IDN meetings
- followed up with individual partners via email as well as 1-1 partner meetings to develop action plans and to address any concerns/barriers to moving forward toward 100% achieved status
- provided trainings by our vendors for all required categories as well as the HIT partner liaison working closely with our partners to facilitate addressing any technical barriers

Performance Measure Name	Target	Progress Toward Target	
		07/01/18 – 12/31/18	As of 6/30/19
Data Extraction and Validation	All 8 IDN member provider entities with Electronic Health Records (EHRs) will develop report templates to allow for data extraction and validation for IDN attributed patients through the use of [redacted] as the data aggregator and data warehouse by July 31, 2018.	Not Achieved: 6 out of 8 provider entities are providing production data to [redacted] for July '18 to Dec '18 reporting period and have met the [redacted] deadline of 02/15/19.	Not Achieved, although 5 out of 8 provider entities are providing production data to [redacted] for Jan '19 to Jun '19 reporting period and will meet the [redacted] deadline of 08/15/19.

Data Extraction and Validation	All of the IDN member provider entities will submit data through the [redacted] manual data portal to meet the reporting requirements for the IDN outcome measures by December 31, 2018.	Achieved: 2 out of 2 member provider entities have entered data manually into [redacted] for July '18 to Dec. '18 reporting period and have met the [redacted] deadline of 02/15/19.	Achieved in prior reporting period, with no additional progress to report.
Secure Data Storage	All IDN Member provider entities who store or capture Protected Health Information (PHI) for IDN attributed patients or who will interact with PHI will have completed annual cyber security reviews of their data storage systems by December 31, 2018 to ensure compliance with NIST capabilities with IDN funding allocations for consultant contracts.	Not Achieved: A total of 16 of 34 organizations have either certified EHRs who complete an assessment as part of their certification requirement or have started the NIST assessment process and are in the process of attestation. Certified EHRs & 2 additional organizations have completed a NIST assessment.	Not Achieved, however a total of 21 of 32 organizations have either certified EHRs who completed an assessment as part of their certification requirement or have completed the NIST/HIPAA assessment process and have submitted or are in the process of submitting attestation.
Direct Secure Messaging (DSM)	All IDN Member provider entities will have the ability to use the protocol Direct Secure Messaging (DSM) to transmit attributed patient information between IDN member entity providers through the use of [redacted] or their own EHR integrated DSM. This interoperability standard will be in use no later than December 31, 2018.	Not Achieved: Out of 34 entities, 16 have the ability to use DSM protocol, 9 of which have certified EHRs and ability to use the protocols. Additionally, 7 executed [redacted] contracts in the reporting period.	Not Achieved, however a total of 21 of 32 organizations have the ability to use DSM protocol.
Shared Care Plan (SCP)	All IDN Member provider entities will have the ability to access and/or contribute to an electronic Shared Care Plan (SCP) for an individual attributed IDN patient to facilitate communication and share data for a team approach to care. It is expected that care coordinators/case managers will be the primary staff to have role-based access the [redacted] SCP platform.	Not Achieved: 3 of 34 entities have completed the [redacted] sub-contracting process and have SCP capabilities.	Not Achieved, however, out of 30 organizations, 6 have the ability to access and/or contributed to SCP, 8 are currently engaged in acquiring [redacted] and 1 does not qualify to access ENS and SCP.

Receive Event Notification Service (ENS)	All IDN Member provider practices/organizations will have the ability to receive alert notifications when patients are admitted, transferred or discharged from a hospital or emergency department. Outpatient providers at primary care and behavioral health practices/organizations will subscribe to receive the event notifications through the [redacted] PreManage platform.	Not Achieved: Out of 31 organizations who are expected to receive ENS, 2 have the ability to receive ENS.	Not Achieved, however out of 30 organizations, 6 have the ability to receive ENS, 8 are currently engaged in acquiring [redacted] for ENS, and 1 does not qualify to access ENS and SCP.
Transmit Event Notification Service (ENS)	St. Joseph Hospital, Southern NH Medical Center and NH Hospital will send and receive ADTs through the use of the [redacted] platform with [redacted] by December 31, 2018. (Note: Modified "3" hospitals to "2" removing NH Hospital)	Not Achieved: Out of 2 hospitals, 1 has the ability to transmit ENS.	Not Achieved with 1 of the IDN hospitals having the ability to transmit ENS. .
Internet Connectivity	All IDN Member provider entities who store or capture Protected Health Information for IDN attributed patients will have a secure Internet connection with support from the IDN by December 31, 2018.	Achieved: All IDN member entities have a secure Internet connection	Achieved in prior reporting period, with no additional progress to report.
Discrete Electronic Data Capture/Closed Loop E-Referrals	Up to 6 of the IDN Member provider entities will have the ability to capture discrete data and/or use Certified Electronic Health Record Technology (CEHRT) as needed by June 30, 2019.	Not Achieved: Awaiting [redacted] Closed Loop Referral functionality build for this solution	Achieved, with Foundation Medical Partners/Southern NH Medical Center having secured a contract with Commonwell. Other partners with EHRs are in process of securing this capability.
Integrated Discrete Secure Messaging (DSM)	Up to 6 of the IDN Member provider entities will have the ability to utilize their EHRs existing Integrated Direct Secure Messaging (DSM) to transmit patient information between providers through the integration of EHRs or cloud-based technologies still to be determined by the IDN by June 30, 2019.	Achieved: 9 partners have existing integrated direct secure messaging technology through their certified EHR systems such as EPIC.	Achieved in prior reporting period with up to 6 partners have existing integrated direct secure messaging technology through their certified EHR systems.
Query-Based Exchange	Up to 6 of the IDN Member provider entities will have the ability to use Inter-Vendor capabilities to share, query and retrieve data.	Achieved: Two IDN partners began the process of securing the ability to share, query, and retrieve data.	Achieved in prior reporting period, with no additional progress to report

Population Health Tools	The IDN Admin Lead will have the ability to identify patients who are high utilizers of provider services through the use of available HIT platforms or newly identified ones by June 30, 2019.	Achieved: SNHMC has been transmitting ENS for all ADT's and our providers now have the ability to monitor high ED utilizers based on default and custom triggers set in the [redacted] PreManage (ambulatory) platform.	Achieved in prior reporting period, with no additional progress to report
Capacity Management Tools	The IDN Admin Lead will have the ability to review and analyze provider utilization (and subsequently availability) through the use of available HIT platforms or newly identified ones by June 30, 2019.	Achieved: The IDN has the ability to access [redacted] submissions for outcome measure analytics and is able to review and analyze provider utilization (and subsequently availability) through the use of available HIT platforms, including [redacted] PreManage platform.	Achieved in prior reporting period, with no additional progress to report
Patient Engagement Technology	The IDN IT/Data Governance Committee will research and make a determination about the feasibility of securing patient engagement technology for IDN provider organizations by December 31, 2018.	Not Achieved: Due to lack of funding the determination has been made to not move forward with patient engagement technology	Achieved, as due to lack of funding, the determination has been made to not move forward with patient engagement technology.
Secure Text	The IDN IT/Data Governance Committee will research and make a determination about the feasibility of procuring secure texting capabilities for IDN provider organizations by December 31, 2018.	Not Achieved: Due to lack of funding the determination has been made to not move forward with securing texting capabilities	Achieved, with 2 IDN partners are working with IDN to secure funding to achieve this functionality

A2-5. IDN HIT: Workforce Staffing

There has been little progress in on-boarding the provider type/roles related to the projected targets. Much of this has been due to those IDN Member providers who have not yet executed IDN sub-contracts and necessary data use agreements to allow for use of IDN staffing allocations for these roles.

Barriers/Challenges and Mitigation Plans

Issue: IDN Admin Lead (SNHMC) Data Analyst role (.10 FTEs) was contracted for several months in late 2018, but has since become vacant.

Issue: PSL's Report Writer/Analyst (.5 FTEs) to support DSRIP Outcome Measure reporting and engagement in the other information sharing platforms has not been on-boarded due to lack of execution of the IDN sub-contract, which has staffing allocation funding to support this role.

Mitigation Strategies:

Mitigation: IDN Admin Lead (SNHMC) Data Analyst role is currently being advertised to provide more capacity for the team as the waiver is now in pay-for-performance, and is replacing the recently vacated Integration Project Manager, which was funded as part of the A1 project. It is expected this role will be on-boarded by Fall 2019.

Mitigation: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets, with the IDN Governance Committees approving the requested changes during the reporting period. The revised project plans are currently being reviewed by DHHS.

Provider Type	IDN Workforce (FTEs)					
	Projected Additional Need for IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
IT/Data Analyst, Manager, Operations	4.7 FTEs	0	2.1	2.6	4.2	4.1
Director	.05	.05	.05	.05	.05	.05

A2-6. IDN HIT: Budget

The focus of funding allocations for this project funding source includes funds to support a variety of staff support, consultants, and education/training.

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $1,972,046.44

- CY 17 (July 2017 – December 2018): $167,999.90
- CY 18 (January 2018 – December 2018): $931,673.46
- CY 19 (January 2019 – December 2019): $436,186.56
- CY 20 (January 2020 – December 2020): $436,186.56

Total funding expended (July 2017 – December 2018): $397,265

- CY 17 (January 2017 – December 2018): $0
- CY 18 (January 2018 – December 2018): $257,917
- CY 19 (January 2019 – June 2019): $139,348

Projections are displayed for the July to December 2019, as well as CY 2020 and 2021 (January to June) in the IDN HIT Budget Table (A2-6a) at the end of this section. Below is more detail to support those budgets.

Funding Allocations/Projections

A2 project strategy funding allocations with projections by funding line item were made to nearly all of the IDN Member Entity provider partners within line items shown below:

- Employee salary/wages to support:
  - data extraction/validation for measures reporting
  - integration interfaces (in-bound and out-bound) to support event notification alerts (one-time allocations)
  - EHR integration of CCDA to support integrated direct secure messaging (DSM) (one-time

allocations)

- Consultants:
  - IDN data warehouse and Quality Reporting Service (QRS) vendor ([redacted]
  - Event Notification Service (ENS) and Shared Care Plan (SCP) platform vendor ([redacted]
  - NIST Cybersecurity Resilience Assessment vendor ([redacted] Technologies)
  - Inter-vendor capabilities to share, query and retrieve data (Commonwell/CareEquality)
  - Ability to send referrals and collect discrete data in a closed loop system

- Equipment:
  - Business grade Internet router and monthly allocations for secure connections to the Internet

- Software:
  - Direct Secure Messaging (DSM) platform vendor ([redacted]

- Sub-contracts/agreements:
  - Vendors previously utilized by IDN provider partners to support data collection and delivery to [redacted] as well as secure other minimum/desired HIT capabilities/standards

- Staff education and training to support:
  - IDN 3 Governance Committee knowledge and skill building for interoperability across primary care, behavioral health and community-based social support service providers

Funding Expenditures

The IDN implements a reimbursement only model for all funding allocations following the state fiscal year (SFY) sub-contract time frame (July – June). For the expenditures reflected in the narrative and budget table below, some of the services were provided during the previous reporting period (July – December 2018) and some invoices have been received, but not fully processed and reflected in the outlined for the current reporting period, including those from Dartmouth Hitchcock and Foundation Medical Partners.

Consultants:

- [redacted]
  - annual contract and interface fees
- [redacted]
  - quarterly fee for [redacted] and Primary
- [redacted] Technologies or KPM Consulting:
  - completion of NIST Cybersecurity/HIPAA assessment and report development for Home Health and Hospice Care, NAMI NH, Lamprey Health, and The Youth Council

Equipment:

- Business grade Internet router and service fees
  - The Emmaus Institute

Software:

- [redacted]
  - IDN sponsorship of annual fees for multiple provider partners

Staff Education and Training:

- [redacted]

- IDN sponsorship of training fees for multiple provider partners

Expenditures that have been invoiced to the IDN, but have not yet been processed and reflected in the table below include:

Employee salary/wages:

- Data extraction/validation for measures reporting
  - Dartmouth Hitchcock
  - Foundation Medical Partners
  - Greater Nashua Mental Health Center (GNMHC)
  - Lamprey Health
  - Southern NH Medical Center
- Integration interfaces (in-bound and out-bound) to support event notification alerts (one-time allocations)
  - Dartmouth Hitchcock
  - Lamprey Health
- EHR integration of CCDA to support integrated direct secure messaging (DSM) (one-time allocations)
  - Dartmouth Hitchcock
  - Lamprey Health

Consultants:

- [redacted] interface fees
- [redacted] ([redacted] quarterly fees for [redacted] and Primary
- NIST Cybersecurity Resilience Assessment vendor ([redacted] Technologies) for several partners who have completed their assessments

A2. 6a IDN HIT
Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan - June 2019 Actuals	July - Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	$442,549	$0	$0	$22,871	$0	$104,919	$209,839	$104,919	$442,549
Employee Benefits	$0	$0	$0	$0	$0	$0	$0	$0	$0
Consultants	$1,232,047	$0	$0	$186,119	$60,518	$246,352	$492,705	$246,352	$1,232,047
Equipment	$120,000	$0	$0	$0	$174	$29,957	$59,913	$29,957	$120,000
Supplies (sum of lines below)	$49,868	$0	$0	$0	$0	$12,467	$24,934	$12,467	$49,868
Educational	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Lab/Pharmacy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Office	$0	$0	$0	$0	$0	$0	$0	$0	$0
Travel (mileage/parking expenses)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Occupancy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Current Expenses (sum of lines below)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Telephone	$0	$0	$0	$0	$0	$0	$0	$0	$0
Internet costs	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postage	$0	$0	$0	$0	$0	$0	$0	$0	$0
Printing and Copying	$0	$0	$0	$0	$0	$0	$0	$0	$0
Audit and Legal	$0	$0	$0	$0	$0	$0	$0	$0	$0
Insurance	$0	$0	$0	$0	$0	$0	$0	$0	$0
Board Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Software	$9,699	$0	$0	$0	$9,699	$0	$0	$0	$9,699
Marketing/Communications	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Education and Training	$86,514	$0	$0	$48,927	$37,587	$0	$0	$0	$86,514
Subcontracts/Agreements	$31,370	$0	$0	$0	$31,370	$0	$0	$0	$31,370
Other (specific details mandatory):	$0	$0	$0	$0	$0	$0	$0	$0	$0
Recruitment Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0
Sign-on Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Referral Bonuses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Relocation Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Student Loan Repayment/Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employee Recognition/Retention Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
CMEs/Professional Development	$0	$0	$0	$0	$0	$0	$0	$0	$0
Professional Development Fees/Dues	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Licensing/Certification Supervision Stipend	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other: please specify below	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	**$1,972,046**	**$0**	**$0**	**$257,917**	**$139,348**	**$393,695**	**$787,391**	**$393,695**	**$1,972,046**

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

Changes to partner engagement:

LaMora Psychological Associates submitted an IDN withdrawal letter in June 2019, outlining concerns with the data reporting requirements as they relate to "various state regulations and ethical concerns." The IDN has submitted this letter to DHHS and is awaiting review/comments with respect to the impact of this new development on the IDN 3 attributed Medicaid population.

Organization Name	Organization Type
American Medical Response (AMR)	Other Organization Type
Ascentria Care Alliance	Community-Based Organization Providing Social and Support Services
Bridges Domestic and Sexual Violence Support	Community-Based Organization Providing Social and Support Services
City of Nashua Department of Public Health	Public Health Organization
Courville Communities	Nursing Facility
Crotched Mountain	Other Organization Type
Dartmouth Hitchcock (DH)	
DH Nashua Family Medicine	Primary and Specialty Care Practices
DH Nashua Internal Medicine	Primary and Specialty Care Practices
DH Hudson	Primary and Specialty Care Practices
DH Merrimack	Primary and Specialty Care Practices
DH Milford	Primary and Specialty Care Practices
DH Nashua Pediatrics	Primary and Specialty Care Practices
Foundation Medical Partners (FMP)	
FMP: Amherst Family Practice	Primary and Specialty Care Practices
FMP: Downtown Medical Associates	Primary and Specialty Care Practices
FMP: Hudson Family Practice	Primary and Specialty Care Practices
FMP: Milford Family Practice	Primary and Specialty Care Practices
FMP: South Nashua Family Practice	Primary and Specialty Care Practices
FMP: Internal Medicine Associates of Nashua	Primary and Specialty Care Practices
FMP: Merrimack Medical Center	Primary and Specialty Care Practices
FMP: Nashua Primary Care	Primary and Specialty Care Practices
FMP: Nashua West Adult Medicine	Primary and Specialty Care Practices
FMP: Pelham Family Medicine	Primary and Specialty Care Practices
FMP: Internal Medicine at Pelham Medical Center	Primary and Specialty Care Practices
FMP: Medicine-Pediatrics of Nashua	Primary and Specialty Care Practices
FMP: Foundation Pediatrics	Primary and Specialty Care Practices
FMP: Main Street Pediatrics and Adolescent Medicine	Primary and Specialty Care Practices
FMP: Internal Medicine	Primary and Specialty Care Practices

Front Door Agency	Community-Based Organization Providing Social and Support Services
Gateways Community Services	Area Agency
Granite State Independent Living (GSIL)	Community-Based Organization Providing Social and Support Services
Greater Nashua Mental Health	Community Mental Health Center and Substance Use Treatment Provider
H.E.A.R.T.S. Peer Support Center	Peer Support and Respite Care
Harbor Homes	Federally Qualified Health Center
Healthy at Home	Community-Based Organization
Hillsborough County Nursing Home and Corrections	County Nursing and Jail Facility
Home Health and Hospice Care	Community-Based Organization Providing Social and Support Services
Keystone Hall	Substance Use Treatment Provider
~~LaMora Psychological Associates~~	~~Behavioral Health Provider~~
Lamprey Health	Federally Qualified Health Center
Life Coping	Other Organization Type
Merrimack River Medical Services	Substance Use Treatment Provider
NAMI NH	Community-Based Organization Providing Social and Support Service
Revive Recovery Support Center	Peer Support
Southern NH Medical Center	Acute Care Hospital Emergency Department, Surgical Center, Inpatient Hospitalization and Substance Use Treatment Provider
Southern NH Services	Community-Based Organization Providing Social and Support Service
St. Joseph Community Services	Community-Based Organization Providing Social and Support Service
St. Joseph Hospital	Acute Care Hospital Emergency Department, Surgical Center
St. Joseph Hospital and Physician Practices (SJH)	
SJH Pediatrics Nashua	Primary and Specialty Care Practices
SJH Pediatrics Milford	Primary and Specialty Care Practices
SJH Pediatrics Sky Meadow	Primary and Specialty Care Practices
SJH Family Medicine, Nashua	Primary and Specialty Care Practices
SJH Internal Medicine	Primary and Specialty Care Practices
SJH Family Medicine and Specialty Services Hudson	Primary and Specialty Care Practices
SJH Family Medicine and Specialty Services Merrimack	Primary and Specialty Care Practices
SJH Family Medicine and Specialty Services Milford	Primary and Specialty Care Practices
SJH Adult Medicine	Primary and Specialty Care Practices
The Emmaus Institute	Mental Health and Substance Use Treatment Provider
The Youth Council	Substance Use Treatment Provider

YMCA of Greater Nashua	Community-Based Organization Providing Social and Support Service
United Way of Greater Nashua	Community-Based Organization Providing Social and Support Service

A2-8. IDN HIT. Data Agreement

Organization Name	Data Sharing Agreement Signed (Y/N) As of 12/31/2018	Data Sharing Agreement Signed (Y/N) As of 6/30/19
Dartmouth Hitchcock (DH)	Y	Y
Foundation Medical Partners (FMP)	Y	Y
Greater Nashua Mental Health (GNMH)	Y	Y
Harbor Homes	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues Q3 2019.	In Progress: being reviewed
Keystone Hall	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues Q3 2019.	In Progress: being reviewed
~~LaMora Psychological Associates~~	~~N~~	~~Formal letter of withdrawal from partner submitted to DHHS~~
Lamprey Health	Y	Y
Merrimack River Medical Services	N	N
St. Joseph Hospital and Physician Practices (SJH)	Y	Y
The Emmaus Institute	Y	Y
The Youth Council	Y	Y

Project Scoring: IDN HIT Process Milestones

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

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

Project B1: Integrated Healthcare

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

Progress, Barriers and Mitigation Plans for Key Milestones and Activities

See attachment_B1.2a: IDN Integrated Healthcare Implementation Plan
See attachment_B1.2b: Narrative Guidance

Implementation Plan Key Milestones

IDN 3's Integrated Healthcare Implementation Plan focuses on the operationalization of 5 key areas:

- Comprehensive Core Standardized Assessment (CCSA)
- Guidelines & Protocols
- Multi-Disciplinary Core Team (MDCT)
- Shared Care Plan (SCP)
- Reporting of outcome metrics

Coordinated & Integrated Care Practice designation

The attached B1 Integrated Healthcare Implementation Plan highlights the milestones towards achievement of Coordinated Care with the ultimate goal of Integrated Care designation. In support of meeting the associated requirements has been the opportunity to periodically assess progress leveraging the UNH Citizens Health Initiative's (CHI) Site Self-Assessment. IDN-3 B1 partner members recently completed their 4th round of the assessment with a 78% (38 of 49) completion rate. This completion rate far exceeds the last SSA completed back in June, 2018 which had a 27% completion due to a minimal amount of 13 of 49 providers executing the assessment. This positive increase in completion rate was due to multiple factors including the engagement of St. Joseph Physician Practices where 12 of their 13 practices participated as compared to last year where none did. Additionally, reinforcing partner member engagement in this activity was a focus area in governance committee meetings (Clinical and Full IDN) as well as via the IDN Admin team partner liaison monthly meetings.

The results from the Site Self-Assessment show that 69% of IDN-3 member partners stayed at the same level towards integrated care as scored within the SAMHSA Six Levels of Integration, 17% went up a level and 14% went down a level. The SSA integration measure member partner breakdown was:

- 17 partners at Co-Located Care III level (score 47-82)
- 13 partners at Co-Located Care IV level (score 83-126)
- 8 partners at Integrated Care V level (score 127-162)

Progress

Progress towards Coordinated Care for IDN-3 partners has continued with advancement with implementation/operationalization of the CCSA, development and attestation of workflows and protocols, and implementation of secure messaging. Each of these components have varying degrees of progress and completion by partner as noted in detail in the appropriate sections below as well as within *attachment B1.2b: Narrative Guidance.*

Barriers/Challenges and Mitigation Plans

The most prevalent barrier to achieving the requirements towards Coordinated Care are the resources necessary to implement and operationalize. Several key partners such as Dartmouth Hitchcock and Lamprey Healthcare have been delayed in implementing the CCSA process due to lack of a Community Health Worker/Resource Specialist in place to support. Other organizations have been challenged in completing the tactical review of the IDN-3 guidelines & protocols and cross-walking them to the documentation they reference as part of their operations environment. Additionally, the IDN-3 Admin team has struggled to support partners through these review processes due to their own resource constraints as well as the lack of clinical expertise within the team.

To address these varying resource constraints, both partner organizations and the IDN-3 Admin team are actively in the midst of hiring clinical support with aggressive plans in place to initiate progress as soon as the individuals are on-boarded. There is anticipation that several of the gaps that have led to delays in meeting requirements will be addressed over the next few months.

Operationalization of the Comprehensive Core Standardized Assessment (CCSA)

Progress

By the end of this reporting period, 6 of the IDN-3 partners have initiated the execution of the CCSA in various stages based on the IDN-3 CCSA Protocols and Guidelines, either manually using the IDN-3 paper version or an electronic version of the IDN-3 CCSA or DH CCSA or another partner specific approved version which has been embedded into their EHR systems with discrete data. While our smaller partners such as The Emmaus Institute and The Youth Council has established process of executing the CCSA for all of their Medicaid clients, some of our larger partners have chosen to begin this process with a sub-population which they have identified as potentially higher risk such as Foundation Medical Center starting with all of their Complex Care Management program clients which services both Medicaid and non-Medicaid patients. One of the goals is that the outcomes resulting from CCSA help to formulate the basis for conversation with the patient and to help create their care plans.

As part of their established monthly reporting, our partners are starting to provide some stories around their IDN Medicaid patient successes and challenges based on positive outcomes from the CCSA process. This has become a basis of discussion on best ways to address the different challenges in referring patients especially for those social determinant of health categories. For example, Dartmouth Hitchcock is expected to use their newly hired IDN funded Resource Specialist to support referral pathways for positive screens related to questions about social determinants of health.

As partners have started operationalizing their CCSA process, they are now able to report the required associated outcome measures to [redacted] that may result from the execution of the CCSA such as Assess.01 (Completion of CCSA), Assess.02 A/B (Depression and SUD screening and follow up) and Assess.04 (Tobacco screening and follow up). Some of our partners have elected to have direct [redacted] portal access to review their measure outcome numbers on a regular basis so that they can make adjustments either to reporting or workflows.

In Q2 of 2019, the IDN has started sharing monthly performance data with all of our [redacted] reporting partners which include management, report writers and clinical representatives. This, in conjunction with their own [redacted] portal access, allows our partners to review what is being reported on their behalf through [redacted] and have the opportunity to make any adjustments prior to [redacted] reporting deadlines to DHHS.

Barriers/Challenges and Mitigation Plans

Partner resource and funding availability and concerns regarding workflow change impact has continued to be an issue where acquiring or identifying the resources and funding necessary to support the end-to-end CCSA process has been a real challenge. Whether it was already existing staffing gaps, adding new workflows to already tight workflows, or resource turnover, this affected execution of project milestones on the clinical side, as well as reporting requirements. For example, one of our partners were stalled due to organization's need to fill the Resource Specialist role, who will support referral pathways for positive screens related to questions about social determinants of health - a CHW ("Resource Specialist") has been hired and starting 7/28/19 with expectation of CCSA operationalization by 9/16/19. To mitigate these challenges:

- Some partners are starting to implement the CCSA process to include all of the 12 domains as pilots for their high risk sub-population. As this gets more traction, we expect the outcome measures to reflect the progress.
- Partner liaisons and IDN Admin Lead continue to work closely with partners to identify gaps and budget planning during the SFY 20 contracting process.
- Uncertainty associated with data sharing, data security and patient confidentiality have been driving partner concern regarding preserving patient information security and confidentiality with new tools and processes being introduced which has delayed sharing the information learned from the CCSA process with primary care partners especially through [redacted] Shared Care Plan platform.

To mitigate these challenges, the IDN-funded InteGreat Health program with Lamprey Health Care, the InteGreat Health Case Manager and Project Manager have been working with the clinical and IT operations team to identify how to easily they can share what is learned with the Lamprey Health primary care provider for use in the client's individualized care plan as well as in the weekly huddles and monthly MDCT case conferences. These types of models can become the basis or model for other MDCT teams.

Operationalization of the Shared Care Plan

Progress

With 6 member partners having now implemented [redacted] ([redacted] platform for the purposes of receiving event notifications, and 8 more actively engaged in the implementation process as noted in the A2 section of this semi-annual report, the infrastructure has now been built for the usage of an electronic shared care plan. Up to this point no IDN-3 member partners have initiated use of the shared care plan component of this platform but due to the active usage of Event Notifications (ENS) the evolution towards the [redacted] shared care plan is in flight and is happening somewhat organically as patient files are loaded.

In the meantime, in support of the requirement to regularly share patient information amongst care team members, parallel discussions are in flight between several IDN-3 member partners as it relates to sharing appropriate data points in support of patient care. Southern NH Medical Center Emergency Department and Behavioral Health Unit and Greater Nashua Mental Health have held meetings over the past few months to discuss initiating the sharing of patients' assigned case managers in the patient eligibility files to [redacted] at least for those patients within the InteGreat, CTI and IDDT programs. This would be a stepping stone towards meeting the requirements and most importantly, would provide information to providers who are subscribing to these shared patients to access a reference point upon discharge to support the continuum of care and avoid gaps as they transition.

Barriers/Challenges and Mitigation Plans

The lack of progress on the operationalization of shared care plans centers on ongoing concerns for IDN-3 partner members related to patient consent due to the sensitivity in data sharing, data security and patient confidentiality. In support of addressing these concerns IDN-3 has adopted a policy to gain patient consent prior to data entry into a shared care plan.

Guidelines & Protocols

See attachment_B1.8hi for IDN-3 Guidelines & Protocols

As noted below under B1-8h "Documented Workflows and/or Protocols in Use and Under Development", IDN-3 completed and distributed their recommended protocols and are in the process of gaining attestation and insight to member partner's status to achievement. See progress, barriers and mitigations as noted under B1-8h and B1-9d below.

Multi-Disciplinary Core Team (MDCT)

Progress has been minimal in the development, implementation and operationalization of MDCTs since last reporting period. In fact, as noted below under B1-8b (Multi-Disciplinary Core Team Members/Roles), B1-8c (Multi-Disciplinary Core Team Service Provider Training), B1-8d (Multi-Disciplinary Core Team Non-Direct Care Staff Training) and, B1-8e (Monthly Case Conference Schedule) the number of MDCT teams identified has actually been reduced since last reporting period.

After revisiting the requirements for a multi-disciplinary core team, IDN-3 determined that the number of teams reported in place last reporting period was over-stated. Rather than 11, there were, and are, 3 actively in place. The teams identified within Foundation Medical Partners were missing some key criteria to meet the requirement hence have been removed leaving the remaining 3: 1 each within Dartmouth Hitchcock, Lamprey Health and the co-located InteGreat Health (Lamprey Health/Greater Nashua Mental Health). See progress, barriers and mitigations as noted below under B1-8b, B1-8c, B1-8d and B1-8e.

Reporting of Outcome Metrics

Progress

Of the 10 IDN Member Entity PCP/MH/SUD providers, 7 are reporting outcome measures to [redacted] either electronically or manually directly into their portal. Our partners have used various methods of doing quality inspections: some complete them during report creation with some after, while others do a combination of both before and after.

The IDN is now able to publish monthly outcome measures performance dashboards to our partners and to our various Governance Committees. The distribution includes report writers, clinical and quality representatives from each provider, project leads and management. For each measure which are required to be reported by IDN partners, the dashboards include:

- the IDN goal % for the measurement period.
- the % of funding allocated with each measure.
- outcome measure details: denominator/numerator/not qualified values and calculated percentage against goal for the measure/for each provider.

This has facilitated conversations within our provider organizations to analyze what is being reported, how it's being reported, as well as what workflows might need to be tweaked through a review of internal clinical policies and procedures. Several of our partners have started to create internal teams consisting of report writers, clinical and quality representatives and leads for these types of discussion.

With the IDN as a whole moving towards data submission and data analytics, there has been a lot of discussion at the Data/IT Governance Committee in the need to form a Collaborative Advisory Sub-Committee focused on reviewing and putting forth recommendations to the established Governance Committees from the perspective of DSRIP Outcome Measure Goals and Platform Usage Data and alignment with funding requirements. This sub-committee would include representatives from various IDN partners as well groups within each partner who would play a role in holistically understanding the DSRIP program patient centered and funding goals with collaboration from both IT and Clinical. It is also expected that the topics brought in front of this sub-committee will help to standardize reporting and use of technology across the IDN. We expect his team to be in place by end of August 2019.

Barriers/Challenges and Mitigation Plans

Meeting measurement goals, especially for Assess.01 (completion of CCSA) which is 37.5% for this reporting period, has been a challenge. Now that there is broad visibility to the reporting and dashboards as a result of monthly data submissions, providers are reviewing the data quality and comparison to other providers and are initiating discussions internally as to improvement opportunities of their outcome measures. Additionally, to provide support and guidance to member partners there have been recent discussions regarding the formation of a Collaborative Advisory Sub-Committee which will focus on data and reporting. The objective, responsibilities and membership make-up have yet to be determined but initial discussions are in flight.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Increased knowledge of universal screening and/or assessment process (Comprehensive Core Standardized Assessment), across 12 domains to guide the treatment and management of the target sub-population.	Up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in universal screening training by December 31, 2018.	Achieved: To date, 25 providers participated in training on universal screening/CCSA implementation. The IDN and its provider partners will ensure additional providers are trained using live and web-based training platforms over the next reporting period to increase the number of providers trained.	Achieved in prior reporting period, with no additional progress to report
Increased knowledge of co-occurring disorders, including physical health conditions such as diabetes hyperglycemia, dyslipidemia, hypertension, with behavioral health conditions to guide the treatment and management of the target sub-population.	Up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in training on co-occurring disorders by December 31, 2018.	Achieved: To date, 31 providers participated in training on co-occurring disorders. The IDN will work to provide additional trainings, using live and web-based training platforms over the next reporting period to increase the number of providers trained.	Achieved in prior reporting period, with no additional progress to report
Increased knowledge of care planning and care coordination models and best practices to guide the treatment and management of the target sub-population.	Up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in care planning and care coordination models and best practices training by December 31, 2018.	Achieved: 63 total MDCT members received training cross all reporting periods by 12/31/18	Achieved in prior reporting period, with no additional progress to report
Increased knowledge of cultural competency and adaptation to guide the treatment and management of the target sub-population.	Up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in cultural competency and adaptation training by December 31, 2018.	Achieved: To date, 43 providers participated in training on cultural competency and adaptation. The IDN (in partnership with Ascentria Care Alliance as the funded trainer) will ensure additional providers are trained using live and web-based to increase the number of providers trained.	Achieved in prior reporting period; No additional progress to report

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Increased knowledge of addiction to guide the treatment and management of the target sub-population.	Up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers across the IDN provider practices will participate in understanding addiction training by December 31, 2018.	Achieved: To date, 23 providers participated in training on addiction. The IDN will ensure additional providers are trained using live and web-based training platforms to increase the number of providers training in the next reporting period.	Achieved in prior reporting period, with no additional progress to report
Increased knowledge of the barriers to health for the IDN's attributed Medicaid target population.	Up to 30 provider practices will implement the CCSA process with the IDN attributed Medicaid population by December 31, 2018.	Achieved: To date, 4 provider organizations (with multiple practices/sites each) have implemented the CCSA process. The IDN will work with treatment provider partners to ensure the CCSA implementation process is in place with all provider organizations over the next reporting period.	Achieved in prior reporting period, however to date, 6 provider organizations (some with multiple practices/sites each) have implemented the CCSA process. The IDN focus is towards those partners who are PCP, MH or SUD providers
Expanded capacity to address behavioral health needs in appropriate settings.	Up to 10 multi- disciplinary core teams will be in place across the IDN to support individuals at risk for or with diagnosed behavioral health conditions or chronic medical conditions within the IDN attributed Medicaid population.	Achieved: 11 MDCTs are in place across 31 practices.	Not Achieved, however 3 MDCTs are in place across 31 practices
Increased knowledge of the emergency department and inpatient admissions, discharges and transfers for the IDN attributed Medicaid population.	Up to 30 provider practices will participate in vendor contracts with [redacted] Event Notification Service (ENS) platform by setting triggers and developing workflows for the receipt and use of event notifications for IDN attributed Medicaid patients in their patient panels.	Not Achieved: Southern NH Medical Center is operational with ENS, with several other partners partially through the on-boarding process and expected to be operational in early 2019. The IDN will provide support to all provider partners to ensure they are engaging in ENS by June 30.	Achieved, with 6 partners are now operational for receiving ENS with 4 others completing their on-boarding to be completed in Q3 2019.

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Improved communication between and among providers in the treatment, management and referral of the target sub-population.	Up to 10 multi- disciplinary core teams will engage in monthly case management for patients with significant behavioral health conditions or chronic medical conditions within the IDN attributed Medicaid population.	Achieved: 8 MDCTs are meeting at least monthly to review complex patients	Not Achieved, however 3 MDCTs are meeting at least monthly to review complex patients
Improved communication between and among providers in the treatment, management and referral of the target sub-population for InteGreat Health, a co- located practice pilot.	Up to 5 number of referrals to other organizations to support the treatment, management, care coordinator or referral of the target sub- population by December 31, 2018.	Achieved: InteGreat Health has exceeded 5 referrals to other organizations this reporting period	Achieved in prior reporting period with additional referrals to other organizations having occurred
New or changed partnerships/ relationships for GNMHC and Lamprey Health (as part of InteGreat Health) with IDN 3 primary care providers, hospitals, peer support organizations, and other direct care providers.	Up to 5 referrals from providers outside of Lamprey Health and/or GNMHC by December 31, 2018.	Achieved: InteGreat Health has received greater than 5 referrals from organizations outside of Lamprey & GNMHC	Achieved in prior reporting period with all referrals for InteGreat come from either GNMH or LHC staff as patients must be eligible for services at GNMH in order to receive care through InteGreat; Referrals to LHC are tracked by category: advertisement, employer, friend, hospital, insurance director, internet/social media, website, other provider, relative, school, and walk in
Increased knowledge and monitoring of information critical to the diagnosis, treatment and management of care for the IDN attributed Medicaid population.	Up to 10 multi-disciplinary core teams will engage in the use of the [redacted] Shared Care plan platform by implementing the IDN protocols and guidelines for patient consent and secure information sharing.	Not Achieved: MDCTs are not yet leveraging [redacted] shared care plan platform	Not Achieved, as no IDN 3 partners are currently leveraging [redacted] shared care plan platform

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Changes in use of technology for workflow or protocols for the treatment, management or referral of the target sub-population.	Up to 20 IDN Member Entities will participate in vendor contracts with [redacted] for their Direct Secure Messaging (DSM) platform, implementing the IDN protocols and guidelines for secure information sharing.	Achieved: 7 IDN Member Entities executed [redacted] contracts by the end of the reporting period, with numerous others in the on-boarding process and are expected to be operational in early 2019.	Achieved in prior reporting period, with 14 IDN Member Entities now having [redacted] DSM capabilities
Increased understanding of integrated health, including increased awareness of where on SAMHSA's Levels of Integrated Care IDN practices/organizations may be.	Up to 30 IDN provider practices will complete a site self- assessment bi- annually, in June and December.	Achieved in prior reporting period: 9 provider practices participated in the June '18 site self –assessment 19 provider practices participated in the Dec '17 site self -assessment 40 provider practices participated in the Jun '17 site self -assessment 6	Achieved in prior reporting period with additional participation in 6/2019 SSA resulted in participation by 36 provider practices
Increased access to primary care, behavioral health and community-based social support services through enhanced care coordination efforts across the IDN.	Up to 60 IDN attributed Medicaid population members who are refugees/immigrants will be supported by a Community Health Worker by December 31, 2018.	Achieved: Ascentria Community Services added 15 new refugee/immigrant enrollments bringing to 18 the number of active cases	Achieved in prior reporting period with Ascentria's current active refugee/immigrant population at 31
Increase in the number of IDN attributed Medicaid population in treatment as a result of provider strategy/ strategies.	Up to 50 unduplicated patients diagnosed with co-occurring mental health and/or substance use disorder will be treated for their primary care needs in a behavioral health setting (through InteGreat Health) by June 30, 2018	Achieved: InteGreat Health saw 98 patients in this reporting period	Achieved in prior reporting period with InteGreat Health having supported 150 unique patients to date
Increase in the number of IDN attributed Medicaid population in treatment as a result of provider strategy/strategies.	All behavioral health patients without an identified primary care provider served by Greater Nashua Mental Health will be targeted for referral into the InteGreat Health program as part of the co-located practice pilot.	Achieved: InteGreat Health enrolled 54 GNMHC behavioral health patients	Achieved in prior reporting period, with InteGreat Health haing enrolled 150 total patients to date, 90 of whom were new to Lamprey Health as their PCP

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Increase in the number of IDN attributed Medicaid population in treatment as a result of Provider strategy/strategies.	All primary care patients who qualify and could benefit from an enhanced integrated model of care will be offered an opportunity to participate in InteGreat Health.	Achieved: InteGreat Health enrolled 44 primary care patients	Achieved in prior reporting period with 83 patients being referred to enroll with InteGreat during the reporting period. All program referrals come from either GNMH or LHC staff as patients must be eligible for services at GNMH in order to receive care through InteGreat.
Reduction in wait time for IDN attributed Medicaid patients waiting to see a treatment provider.	Wait times for intakes for patients of Lamprey Health and Greater Nashua Mental Health (as patients of InteGreat Health) will be reduced from a current average of 7- 45 days to no more than 72 hours by December 31, 2020 through the implementation of the Open Access.	Achieved: The target wait time of <72 hours has not been achieved but progress has been made from 36% of routine referrals to GNMHC seen within 14 days to 96% in this reporting period	Achieved with greater than 95% of routine referrals are seen within 14 days of initial contact; in this reporting period 84% of those who requested services were seen the same day
Increase in the number of IDN attributed Medicaid population patients receiving well-care (annual physical) visits.	Up to 25% increase in well-care visits completed within InteGreat Health program by December 31, 2020.	Progress Met: The increase for well-care visits to InteGreat Health surpassed the 25% increase target	Achieved in prior reporting period with InteGreat Health having enrolled 150 total patients to date, 90 of whom were new to Lamprey Health as their PCP

B1-4. IDN Integrated Healthcare: Workforce Staffing

Provider Type	IDN Workforce (FTEs)					
	Projected Additional Workforce Needed for IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Psychiatrist	1.95	.26	.26	.76	.93	.82
Psychiatric APRN	1.3	0	0	0	0	0
Psychiatric Certified Nurse	1	0	0	0	0	0
Physician's Assistant (Certified)	0.2	0	0	.2	.2	.2
Nurse Practitioner	.28	0	0	0	.28	.28
Registered Nurse	1.7	0	0	0	.5	.5
Consulting Pharmacist	.2	0	0	0	0	.2
Medical Assistant	.28	0	0	.28	.28	.28
Licensed Therapist	6.02	0	4.75	4.78	4.99	4.96
Master's Licensed Alcohol and Drug Counselor (MLADC)	14	0	0	0	2	4
Behavioral Health Clinician/Specialist	18.6	0	4	4	14	17
Behavioral Health Coordinator	4	0	0	0	0	0
Case Manager	9.5	0	0	3	5	6
Care Coordinator	17.25	5	6	9	10.75	16.75
Community Health Worker	8.71	0	1	3	3	1.71
Criminal Justice Specialist/Liaison	0.1	0	0	.1	.1	.1
Supportive Employment Specialist	0.5	0	0	.5	0	.5
Housing Specialist	0.1	0	0	.1	.1	.1
Family Specialist	0.1	0	0	.1	.1	.1
Peer Support Specialist	1.53	0	0	1	1	1
Administrative Office/Billing	2.37	.75	1.1	1.37	1.1	1.1
Clinical Operations	.2	0	.2	.2	.2	.2
IT/Data Analyst, Manager, Operations	4.7	0	2.1	2.6	4.2	4.1
Program Evaluation Specialist	.5	0	0	0	.5	.5
Project Manager	2.5	0	1.5	1.5	2.5	2.5
Marketing/Education	.20	0	.20	.20	.20	.20

There has been little progress in on-boarding the provider type/roles related to the projected targets. Much of this has been due to those IDN Member providers who have not yet executed IDN sub-contracts and necessary data use agreements to allow for use of IDN staffing allocations for these roles.

Psychiatrist

All of these gaps in meeting the targets were related to on-boarding/identifying psychiatric representation for individual MDCTs (Merrimack River Medical Services, St. Joseph Hospital and Physician Practices, and the Partnership for Successful Living), for which the IDN has allocated funds to support.

Barriers/Challenges: All of these providers have not yet executed IDN sub-contracts to allow their use of approved funding allocations, which has prevented them from on-boarding this provider role.

Mitigation Strategies: During the reporting period, the IDN has been working with the Clinical Governance Committee to identify protocols/workflows and processes for conducting a regional IDN MDCT. This was approved in June, to support those partners who have not yet stood up their MDCTs and/or require access to a MDCT, which includes those targeted to on-board the psychiatric role for their team.

The IDN expects to operationalize this monthly MDCT model in the next reporting period, with leadership from the IDN Clinical Governance Committee, as well as through sub-contracting with a clinical consultant.

Registered Nurse

Barriers/Challenges:

The Partnership for Successful Living (Harbor Homes and Keystone Hall), who indicated they would on-board a detox nurse (.6 FTEs) and non-detox nurse (.6 FTEs) has not yet executed the IDN sub-contract to date.

Mitigation Strategies:

The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets. During the reporting period, the IDN Governance Committees approved the changes in scope and budget. Revised project plans (which have been submitted to DHHS for review) reflect changes in the targets, with PSL noting that MLADCs are not billable under FQHCs, and therefore requesting to use supervision stipends to support staff moving to an LICSW or LCMHC.

Licensed Therapist

Barriers/Challenges:

- GNMH CTI Team Lead: previous role was a licensed therapist (1 FTE).
- GNMH Community-Based Groups Facilitator: In March 2019, GNMH notified the IDN that they would not be moving forward with implementing these weekly groups, so this strategy (and its designated staffing at .03 FTEs) will not move forward.

Mitigation Strategies:

GNMH CTI Team Lead: GNMH has determined this team member could now become a Bachelor's Level role, serving 25% time administrative/supervision and 75% case management, with the addition of a .15 FTE Clinical Supervisor role. The individual currently serving this role was previously a CTI Specialist who was moved to the Team Lead role, with a new individual filling their vacant role.

MLADCs

Barriers/Challenges: The gaps in hitting the targets for this provider type relate to lack of progress in the achievement of additional MLADC-certified staff outlined in our partners' project plans. This included:

- Partnership for Successful Living (Harbor Homes and Keystone Hall), who indicated they would target up to 8 Master's Level clinicians who would benefit from IDN stipends to offset the supervision time of staff. They were not able to make progress in this target, due to not executing IDN sub-contracts with funds to support these strategies during the reporting period.
- Greater Nashua Mental Health, who indicated they would target up to 4 Master's Level staff achieving certification.
- Southern NH Medical Center, who has 1 Master's Level staff person targeted to achieve MLADC certification.
- LaMora Psychological Associates has struggled with meeting the NH State Statutes for data sharing related to this role (.03 FTEs) and has been working with the NH State Board, as well as their legal counsel to identify next steps to allow them to engage.

Mitigation Strategies:

- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets. During the reporting period, the IDN Governance Committees approved the changes in scope and budget.
  - Revised project plans (which have been submitted to DHHS for review) reflect changes in the targets, with PSL noting that MLADCs are not billable under FQHCs, and therefore requesting to use supervision stipends to support staff moving to an LICSW or LCMHC.
- GNMH has made significant progress in meeting their goals, with 3 out of the 4 staff members achieving MLADC certification.
  - GNMH has utilized IDN funding to support supervision stipends and will continue to receive these incentive funds into the next reporting period to support the remaining 1 staff member targeted to achieve MLADC certification.
- SNHMC's SUD Acute/Transitional Care Coordinator is still working on her certification, but not having achieved it to date. However, the IDN has provided additional funds to support her attendance at the New England School of Addiction and Prevention Studies in July.
- LaMora provided a formal letter in June 2019 requesting to be removed from IDN-3 due to its ethical challenges for sharing behavioral health data. This letter has been provided to DHHS to determine how this development affects the region's Medicaid attributed lives.

Behavioral Health Clinician/Specialist

There has been progress in on-boarding this provider role, with Dartmouth Hitchcock on-boarding their second clinician during this reporting period.

Barriers/Challenges:

- St. Joseph Hospital and Physician Practices (SJH) has not executed the IDN sub-contract to allow them to access B1 project funding allocations to support the adult (1 FTEs) and pediatric (.6 FTEs) behavioral health consultants. Their approved project strategies included potentially partnering with GNMH to support sub-contracting these roles.

- Both GNMH and The Youth Council were targeting up to 6 Master's Level interns who would support their intern cohort under this provider role, with 4 initially on-boarding in September 2018 and 2 subsequently leaving the cohort due to receiving other opportunities.
- The Youth Council received IDN funding to support 3 positions to support their Project IMPACT program in the Nashua Middle Schools. To date 2 of those individuals have been retained, with one leaving their role in early 2018.

Mitigation Strategies:

- The IDN continues to work with SJH to identify how to best move forward in their B1-related strategies, which include these 1.6 FTEs for behavioral health staff. With the ongoing challenges associated with the merger with Covenant Health and migration to a new EHR, SJH has shared that leadership is still trying to identify what makes the most sense for their organization moving forward to achieve the IDN deliverables.
- The Master's Level intern cohort funded strategy for GNMH and The Youth Council was only targeted to occur for the September 2018 – May 2019 academic year.
- The Youth Council Project IMPACT vacancy was filled through their D3 project goal of expanding access to SUD treatment for adolescents/young adults, so this role is now represented under the MLADC provider role category.

Behavioral Health Coordinator

Barriers/Challenges: The 2 FTEs under this provider role were part of the original project plans for Foundation Medical Partners (FMP) and Merrimack River Medical Services (MRMS).

- FMP determined it would not move forward with accepting IDN-approved funds to support this role as part of its B1 strategies and therefore, is utilizing its existing Master's Level Behavioral Health Clinicians/Specialists who are embedded in some of their practices to support their achievement of Coordinated Care Practice designation.
- MRMS has not yet executed its sub-contract with the IDN, but has had several meetings with the IDN Admin Lead that has included their Regional Vice President under Baymark, with who they merged in early 2018.

Mitigation Strategies:

- FMP: The IDN will continue to work closely with both FMP and their existing staffing capacity to document achievement of reaching Coordinated Care Practice designation and making progress toward Integrated Care Practice designation.
- MRMS leadership (including the delegate serving on the IDN Clinical Governance Committee) has indicated they are anxious to move forward with being an active member of the IDN and achieving Coordinated Care Practice designation and plans to continue to work together in the next reporting period to executive sub-contracts and achieve required deliverables.

Case Manager (Bachelor's and Master's Level)

Barriers/Challenges:

- GNMH has not on-boarded its .5 FTEs CTI Specialist, as the team feels it has not needed the additional capacity to date due to current enrollments.
- PSL identified 4 FTEs Integrated Care Case Managers to be supported by IDN funds in moving their three partner organizations (Harbor Homes, Keystone Hall and Healthy at Home) together toward

Coordinated Care Practice designation. To date, IDN sub-contracts have not been executed and therefore, funds have not been released to support on-boarding these roles.

Mitigation Strategies:

- GNMC is working closely with the IDN and IDN-funded technical assistance provider/trainer, [redacted] to increase their enrollment and therefore the need to on-board their approved CTI Specialist (.5 FTEs) through engaging in 1:1 technical assistance/implementation coaching and fidelity training over the coming months.
- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets, with the IDN Governance Committees approving the requested changes during the reporting period.
    - These changes reflected not filling the 4 FTEs case managers and instead, outlining the need to support LPNs, LDACs, LICSWs, and/or CRSWs (3 FTEs). These project plan revisions are being reviewed by DHHS.

Care Coordinator (Bachelor's and Master's Level)

Barriers/Challenges: The remaining .5 FTEs Care Coordinator is associated with St. Joseph Hospital, as this role was approved as an emergency department SUD Acute/Transitional Care Coordinator. However, SJH has not executed their IDN sub-contract and scope of work for this D3 project funding allocation to date.

Mitigation Strategies: The IDN continues to work with SJH to identify how to best move forward in their D3-related strategies, which include this .5 FTE care coordinator in the emergency department, similar to what has been operationalized with SNHMC. With the ongoing challenges associated with the merger with Covenant Health and migration to a new EHR, SJH has shared that leadership is still trying to identify what makes the most sense for their organization moving forward to achieve the IDN deliverables.

Community Health Worker (CHW)

Barriers/Challenges:

- PSL identified 1 FTE CHW to be supported by IDN funds in moving their three partner organizations (Harbor Homes, Keystone Hall and Healthy at Home) together toward Coordinated Care Practice designation. To date, IDN sub-contracts have not been executed and therefore, funds have not been released to support on-boarding these roles.
- Dartmouth Hitchcock Community Resource Corps/Americorps VISTA: while IDN-3 partner organizations requested up to 5 CHWs under this program (to be allocated to Harbor Homes, SNHMC, GNMH, Nashua Department of Public Health, and St. Joseph Hospital and Physician Practices), only 2 were filled due to CHW interest and were subsequently placed with the Nashua Department of Public Health and St. Joseph Hospital.
    - These two CHWs ended their Community Resource Corps program with DH, with DH working with the IDN to potentially have a second round of CHWs, but this has not been confirmed to date.
- Dartmouth Hitchcock: These roles (under the title *Resource Specialist)* were targeted to support the MDCT and the implementation of the CCSA across the DH Nashua practices. One of the roles

will be on-boarded in July 2019, with the other pending approval of supplemental funds requested by DH from the IDN.

  - Supplemental funding proposals were submitted in the Fall 2018 from numerous IDN Member Entities, with several being recommended by the IDN Clinical Governance Committee to move forward.

Mitigation Strategies:

- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets, with the IDN Governance Committees approving the requested changes during the reporting period.
  - These changes reflected not filling the 1 FTE CHW and instead, outlining the need to support LPNs, LDACs, LICSWs, and/or CRSWs (3 FTEs). These project plan revisions are being reviewed by DHHS.
- Dartmouth Hitchcock: The IDN continues to work with DH and its Governance Committees to get confirmation of county funding contributions as well as how its partners will actually expend approved funds to determine next steps in funding supplemental funding proposals such as the one provided by DH.

Peer Support Specialist

Barriers/Challenges: the gaps in the .53 FTEs for this role include the following:

- GNMH weekly pre-treatment community-based groups: In March 2019, GNMH notified the IDN that they would not be moving forward with implementing these weekly groups, so this strategy (and its designated staffing) will not move forward.
- GNMH IDDT strategy: GNMH has determined this position is not needed to meet program fidelity per technical assistance provided by IDN-funded technical assistance/training provider Case Western Reserve University.

Administrative Office/Billing

Barriers/Challenges:

- Foundation Medical Partners (FMP): 1 FTE Receptionist was targeted to support their B1 project allocation to move the organization and its designated practices forward with Coordinated Care Practice designation. However, FMP determined it would not move forward with accepting IDN-approved funds to support this role.

IT/Data Analyst, Manager, Operations

Barriers/Challenges:

- IDN Admin Lead (SNHMC) Data Analyst role (.10 FTEs) was contracted for several months in late 2018, but has since become vacant.
- PSL's Report Writer/Analyst (.5 FTEs) to support DSRIP Outcome Measure reporting and engagement in the other information sharing platforms has not been on-boarded due to lack of execution of the IDN sub-contract, which has staffing allocation funding to support this role.

Mitigation Strategies:

- IDN Admin Lead (SNHMC) Data Analyst role is currently being advertised to provide more capacity for the team as the waiver is now in pay-for-performance, and is replacing the recently vacated Integration Project Manager, which was funded as part of the A1 project. It is expected this role will be on-boarded by Fall 2019.
- PSL: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets, with the IDN Governance Committees approving the requested changes during the reporting period. The revised project plans are currently being reviewed by DHHS.

B1-5. IDN Integrated Healthcare: Budget

B1 project strategies and subsequent funding allocations were mostly allocated to support workforce to build the staffing capacity to achieve the integrated health goals of achieving Coordinated Care Practice designation and move toward Integrated Care Practice designation.

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $5,551,246.68

- CY 17 (July 2017 – December 2017): $763,959.00
- CY 18 (January 2018 – December 2018): $1,672,841.24
- CY 19 (January 2019 – December 2019): $1,571,673.24
- CY 20 (January 2020 – December 2020): $1,569,173.24

Total funding expended (July 2017 – June 2019): $701,927

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $302,214
- CY 19 (January 2019 – June 2019): 399,713.00

Projections are displayed for the July to December 2019, as well as CY 2020 and CY 2021 (January to June) in the IDN HIT Budget Table (B1-5a) at the end of this section. Below is more detail to support those budgets.

Approved funding allocations/projections

The focus of funding allocations for this project funding source includes funds to support a variety of staff support, consultants, and education/training. These include:

Employee salary/wages (including expenses such as supplies, equipment, travel/parking, printing/copying, software, occupancy, sub-contracts, etc. associated with salary/wages and benefits) to support the IDN 3 integrated health care team strategies to meet Coordinated Care Practice designation and SAMHSA Plus milestones/deliverables, as well as make progress along the SAMHSA Integrated Care Practice designation milestones/deliverables:

- Psychiatric (Psychiatrist, Psychiatric APRN, Psychiatric Certified Nurse)
- Physician Assistant
- Consulting Pharmacist
- Medical Assistant
- Licensed BH Therapist/Clinician
- Master's Licensed Alcohol and Drug Counselors (MLADCs)
- Behavioral Health Clinician/Specialist
- Care Coordinator/Case Manager/Community Health Workers

- Housing, Family and Peer Support Specialists
- Administrative Office/Billing
- Clinical Operations
- IT/Data Analyst, Manager, Operations
- Program Evaluation Specialist
- Project Managers
- Marketing/Education

Consultants to support:
- Change management
- Value-based payment models
- Open Access technology and changes in workflows
- Same day access gap analysis and onsite consultation

Equipment:
- Capital expenses associated with renovation and build-out of InteGreat co-located practice space

Current expenses:
- audit and legal services associated with co-located practice start-up and operations

Marketing and communications:
- provider education
- community education/messaging for new services

Staff education and training:
- Co-located practice trainings for change management
- Open Access expenses associated with "lost staff time" to support implementation

Other:
- Indirect costs, capped at 15% per the IDN 3 Finance Governance Committee for all IDN Member Entity sub-contracts

Funding expenditures during reporting period

The IDN implements a reimbursement only model for all funding allocations following the state fiscal year (SFY) sub-contract time frame (July – June). For the expenditures reflected in the narrative and budget table below, some of the services were provided during the previous reporting period (July – December 2018) and some invoices have been received, but not fully processed and reflected in the outlined for the current reporting period.

Employee salary/wages (including expenses such as supplies, equipment, travel/parking, printing/copying, software, occupancy, sub-contracts, etc. associated with salary/wages and benefits):
- Dartmouth Hitchcock:
  - Behavioral Health Clinicians (1 FTE through Feb 2019; 2 FTEs Feb – June 2019)
- GNMHC:
  - Marketing/communications staff time for InteGreat program
- Lamprey Health:
  - Marketing/communications staff time for InteGreat program

Consultants:

- Open Minds (GNMH)
  - Transition to value-based payments

Equipment:

- Dartmouth Hitchcock:
  - Computers for 2 BH Clinicians

Current Expenses:

- Lamprey Health (audit/legal):
  - data sharing for co-located practice

Marketing and communications:

- GNMHC/InteGreat:
  - water bottles
  - banner and signage
  - mental health awareness decorations

Staff education and training:

- Lamprey Health:
  - Nutritional and Integrative Interventions for Mental Health Disorders

Sub-contracts/agreements:

Other (indirect costs, capped at 15% per IDN Finance Committee):

- Dartmouth Hitchcock
- Greater Nashua Mental Health
- Lamprey Health

B1-5a: IDN Integrated Healthcare
Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan - June 2019 Actuals	July - Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	$4,864,107	$0	$0	$14,787	$0	$1,212,330	$2,424,660	$1,212,330	$4,864,107
Employee Benefits	$0	$0	$0	$0	$0	$0	$0	$0	$0
Consultants	$66,156	$0	$0	$43,310	$22,846	$0	$0	$0	$66,156
Equipment	$199,803	$0	$0	$195,729	$4,074	$0	$0	$0	$199,803
Supplies (sum of lines below)	$10,637	$0	$0	$9,341	$1,296	$0	$0	$0	$10,637
Educational	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Lab/Pharmacy	$0	$0	$0	$0	$487	$0	$0	$0	$487
Office	$0	$0	$0	$0	$809	$0	$0	$0	$809
Travel (mileage/parking expenses)	$713	$0	$0	$0	$713	$0	$0	$0	$713
Occupancy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Current Expenses (sum of lines below)	$35,406	$0	$0	$18,954	$16,452	$0	$0	$0	$35,406
Telephone	$0	$0	$0	$0	$440	$0	$0	$0	$440
Internet costs	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postage	$0	$0	$0	$0	$0	$0	$0	$0	$0
Printing and Copying	$0	$0	$0	$0	$383	$0	$0	$0	$383
Audit and Legal	$0	$0	$0	$0	$15,629	$0	$0	$0	$15,629
Insurance	$0	$0	$0	$0	$0	$0	$0	$0	$0
Board Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Software	$317	$0	$0	$0	$317	$0	$0	$0	$317
Marketing/Communications	$389	$0	$0	$389		$0	$0	$0	$389
Staff Education and Training	$19,903	$0	$0	$19,703	$200	$0	$0	$0	$19,903
Subcontracts/Agreements	$302,239	$0	$0	$0	$302,239	$0	$0	$0	$302,239
Other (specific details mandatory):	$0	$0	$0	$0	$0	$0	$0	$0	$0
Recruitment Fees		$0	$0	$0	$0	$0	$0	$0	$0
Sign-on Bonus		$0	$0	$0	$0	$0	$0	$0	$0
Staff Referral Bonuses		$0	$0	$0	$0	$0	$0	$0	$0
Relocation Expenses		$0	$0	$0	$0	$0	$0	$0	$0
Student Loan Repayment/Reimbursement		$0	$0	$0	$0	$0	$0	$0	$0
Employee Recognition/Retention Bonus		$0	$0	$0	$0	$0	$0	$0	$0
CMEs/Professional Development		$0	$0	$0	$0	$0	$0	$0	$0
Professional Development Fees/Dues		$0	$0	$0	$0	$0	$0	$0	$0
Staff Licensing/Certification Supervision Stipend		$0	$0	$0	$0	$0	$0	$0	$0
Other: please specify below	$51,576	$0	$0	$0	$51,576	$0	$0	$0	$51,576
TOTAL	**$5,551,247**	**$0**	**$0**	**$302,214**	**$399,713**	**$1,212,330**	**$2,424,660**	**$1,212,330**	**$5,551,247**

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

Certificates of Authorization and Certificates of Vote have been executed with all of the IDN Member Entity provider partners to date, enabling the IDN to move forward with implementation plans and budgets. During the reporting period, LaMora Psychological Associates submitted an IDN withdrawal letter based on concerns with the data reporting requirements as they relate to "various state regulations and ethical concerns." The IDN has submitted the letter to DHHS and is awaiting next steps after their review.

Organization/Provider (Signed at the parent agency level – not the practice level)	Agreement Executed (Y/N)
Dartmouth Hitchcock	Y
Foundation Medical Partners	Y
Greater Nashua Mental Health	Y
Harbor Health/Harbor Care Health and Wellness Center	Y
Healthy at Home	Y
Keystone Hall	Y
~~LaMora Psychological Associates~~	~~Y~~
Lamprey Health Care	Y
Merrimack River Medical Center	Y
Southern NH Medical Center	Y
St. Joseph Hospital and Physician Practices	Y
The Emmaus Institute	Y
The Youth Council	Y

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

Name	Title	Organization	Sign Off Received (Y/N)
Craig Amoth	Chief Executive Officer	Greater Nashua Mental Health	Y
Mike Apfelberg	President	United Way of Greater Nashua	Y
Bobbie Bagley	Director	City of Nashua Division of Public Health	Y
Paul Bergeron	Commissioner	Hillsborough County	Y
Kathy Cowette	Director of Planning	St. Joseph Hospital	Y
Carol Furlong	Vice President of Operations	Partnership for Successful Living	Y
Ken Lewis	Executive Director	HEARTS Peer Support Center	Y
Jonathan Thyng	Physician	Dartmouth Hitchcock Nashua	Y
Greg White	Chief Executive Officer	Lamprey Health	Y
Lisa Madden	Assistant Vice President of Behavioral Health	Southern NH Health	Y
Marilou Patalinjug Tyner	Chief Medical Officer	Greater Nashua Mental Health	Y
Cynthia Whitaker	Chief of Services	Greater Nashua Mental Health	Y
Susan Stearns	Deputy Director	NAMI NH	Y

B1-8a. CCSA Domains

See attachment_B1.8a CCSA Domains in Use by IDN Provider Practice

As noted in the CCSA domain by partner attachment, almost all IDN-3 member partners have all required domains already in place. The two outliers are Merrimack River Services and several St. Joseph Physician Practices both of which do not have signed subcontracts with the IDN and are noted as having some domains in process. As noted elsewhere in this report, all efforts are being exhausted to engage these partners in the demonstration. It is anticipated that once they do sign their subcontracts and engage, that it will be a relatively minimal effort to implement and operationalize all required domains into their assessment processes.

B1-8b. Multi-Disciplinary Core Team Members/Roles

Progress

As mentioned above in the B1-2 implementation plan narrative, there has been little progress to report as it relates to development of MDCTs. IDN-3 has 3 partner member MDCT teams who are actively in progress towards finalizing requirements: 1 each within Dartmouth Hitchcock, Lamprey Health and the co-located InteGreat Health (Lamprey Health/Greater Nashua Mental Health). Each MDCT has different criteria for the patient panels they focus on. For Dartmouth their MDCT discusses their most complex patients with completed PHQ2 or PHA9s which require referrals. Lamprey's MDCT focuses on patients their providers are struggling with due to diagnosis challenges and that present in need of additional resources. And lastly InteGreat, who has office hours twice a week, has care coordination meetings after each of the two days and discusses all patients seen that particular day (in light of every patient having SPMI as well as oftentimes a complex medical diagnosis).

The table below reflects all of the B1 provider practices with those providers in gray who do not have MDCTs which meet the waiver requirements.

Barriers/Challenges and Mitigation Plans

13 of 39 (33%) provider practices are in limbo in engaging in finalization of MDCT requirements due to lack of signed subcontracts hence significantly impacting this goal. This includes Merrimack River Medical Services, Partnership for Successful Living (Harbor Homes, Keystone Hall, Healthy at Home), and St. Joseph Physician Practices (9 practices). Several of those member partners who do have subcontracts, and who are behavioral health providers (vs primary care) do not yet have a formalized path to refer to, and participate on, a multi-disciplinary team structure. This includes Greater Nashua Mental Health, The Emmaus Institute and The Youth Council. And lastly there are primary care practices that have subcontracts but there is a lack of clarity as to the formalized structure of care coordination teams and the required criteria to be considered an "MDCT". This group includes several Dartmouth Hitchcock practices and the Foundation Medical Partner practices.

To mitigate the gap in achievement of the MDCT requirements, IDN-3 has received governance funding approval and presented a proposal to a Clinical Consultant whose immediate task upon onboarding will be to design a regional multi-disciplinary core team, develop protocols, roles, responsibilities, engage all IDN-3 B1 partners, identify team members, and initiate the monthly meeting cadence. The target for launch is within 1 month of this individual's onboarding.

MDCT Team #	Provider Practices with Multi- Disciplinary Core Team (MDCT)	MDCT Member Status
1	**Dartmouth Hitchcock (DH) Practices**	
	DH Nashua Family Medicine	
	Provider, MD	In place
	Psychiatrist, MD	In place
	Behavioral Health Clinician, LICSW	In place
	Care Coordinator, MSW	In place
	DH Nashua Pediatrics DH Nashua Internal Medicine	
	DH Hudson	
	DH Milford	
	DH Merrimack	
	Foundation Medical Partners (FMP) Practices	
	Amherst Family Practice	
	Milford Family Practice	
	South Nashua Family Practice	
	Hudson Family Practice	
	Pelham Family Medicine	
	Downtown Medical Associates	
	Internal Medicine Associates of Nashua	
	Merrimack Medical Center	
	Nashua Primary Care	
	Nashua West Adult Medicine	
	Internal Medicine at Pelham Medical Center	
	Foundation Internal Medicine	
	Medicine-Pediatrics of Nashua Foundation Pediatrics	
	Main St. Pediatrics & Adolescent Medicine	
	Greater Nashua Mental Health	
	Harbor Homes	
	Healthy at Home	
2	**InteGreat Health co-located between Lamprey Health and GNMHC**	
	Provider, MD	In place (Lamprey Health)
	Consulting Psychiatrist, MD	In place (GNMHC)
	Physician Assistant, PA	In place (Lamprey Health)
	Physician Assistant, PA	In place (Lamprey Health)
	BH Clinician, LCMHC	In place at GNMHC
	Clinical Care Coordinator, MSW	In place (Lamprey Health)
	Clinical Operations Management	In place (Lamprey Health & GNMHC)

	Keystone Hall	
	~~LaMora Psych Associates~~	
3	**Lamprey Health**	
	Provider, MD	In place
	Consulting Psychiatrist, MD	In place
	Physician Assistant, PA-C	In place
	BH Clinician	In place
	BH Clinician	In place
	Clinical Care Coordinator	In place
	Clinical Operations Management	In place
	Merrimack River Medical Services	
	St. Joseph Hospital and Physician Practices (SJH)	
	SJH Pediatrics Nashua	
	SJH Pediatrics Milford	
	SJH Pediatrics Sky Meadow	
	SJH Family Medicine, Nashua	
	SJH Internal Medicine	
	SJH Family Medicine & Specialty Services Hudson	
	SJH Family Medicine & Specialty Services Merrimack	
	SJH Family Medicine & Specialty Services Milford	
	SJH Adult Medicine	
	The Emmaus Institute	
	The Youth Council	

B1-8c. Multi-Disciplinary Core Team Service Provider Training

See attachment_B1.8ci: Multi-Disciplinary Team Training Schedule

Progress

Even with the paring back of multi-disciplinary core teams from 11 to 3, progress towards training requirements for the identified MDCT members was minimal. Although training opportunities offered to all IDN partner members and staff increased multi-fold (from ~26 to ~60), was delivered in varying formats (in-person, webinar, pre-recorded webinar), and were publicized bi-weekly, the resulting ~300 total attendees had minimal MDCT members participated. The IDN-3 publicized trainings included what is noted in attachment B1.8ci: Multi-Disciplinary Team Training Schedule.

The 14 identified MDCT members varied in their level of engagement in the required trainings and included:

MDCT Team #	Provider Practices with Multi- Disciplinary Core Team (MDCT)	Trained in the Following Topics					
		Universal Screening	Understanding Addiction	Cultural Competency	Care Planning/ Coordination	Co-occurring Disorder	Mental Health First Aid
1	**Dartmouth Hitchcock (DH) Practices**						
	DH Nashua Family Medicine						
	Provider, MD (1)	y	y	y			y
	Psychiatrist, MD (1)	y					
	Behavioral Health Clinician, LICSW (1)						
	Care Coordinator, MSW (1)					y	
	DH Nashua Pediatrics						
	DH Nashua Internal Medicine						
	DH Hudson						
	DH Milford						
	DH Merrimack						
	Foundation Medical Partners (FMP) Practices						
	Amherst Family Practice						
	Milford Family Practice						
	South Nashua Family Practice						
	Hudson Family Practice						
	Pelham Family Medicine						
	Downtown Medical Associates						
	Internal Medicine Associates of Nashua						
	Merrimack Medical Center						
	Nashua Primary Care						
	Nashua West Adult Medicine						
	Internal Medicine at Pelham Medical Center						
	Foundation Internal Medicine						
	Medicine-Pediatrics of Nashua						
	Foundation Pediatrics						
	Main St. Pediatrics & Adolescent Medicine						
	Greater Nashua Mental Health						
	Harbor Homes						
	Healthy at Home						
		Universal Screening	Understanding Addiction	Cultural Competency	Care Planning/ Coordinatio n	Co-occurring Disorder	Mental Health First Aid
2	**InteGreat Health co-located between Lamprey Health and GNMHC**						
	Provider, MD (1)		y				

	Consulting Psychiatrist, MD (1)	y	y	y		y	
	Physician Assistant, PA (1)		y		y	y	
	BH Clinician, LCMHC (1)	y	y	y		y	
	Clinical Care Coordinator, MSW (1)	y		y	y	y	
	Keystone Hall						
	~~LaMora Psych Associates~~						
		Universal Screening	**Understanding Addiction**	**Cultural Competency**	**Care Planning/ Coordination**	**Co-occurring Disorder**	**Mental Health First Aid**
3	**Lamprey Health**						
	Provider, MD (1)		y				
	Consulting Psychiatrist, MD (1)	y	y	y		y	
	Physician Assistant, PA-C (1)		y		y	y	
	BH Clinician (1)				y	y	
	Clinical Care Coordinator (1)	y		y	y	y	
	Merrimack River Medical Services						
	Partnership for Successful Living coordinated care across Harbor Homes, Keystone Hall and Healthy at Home						
	Harbor Health/Harbor Care Health and Wellness Center						
	Keystone Hall						
	Healthy at Home						
	St. Joseph Hospital and Physician Practices (SJH)						
	SJH Pediatrics Nashua						
	SJH Pediatrics Milford						
	SJH Pediatrics Sky Meadow						
	SJH Family Medicine, Nashua						
	SJH Internal Medicine						
	SJH Family Medicine & Specialty Services Hudson						
	SJH Family Medicine & Specialty Services Merrimack						
	SJH Family Medicine & Specialty Services Milford						
	SJH Adult Medicine						
	The Emmaus Institute						
	The Youth Council						

B1-8d. Multi-Disciplinary Core Team Non-Direct Care Staff Training

Non-Direct Staff were not clearly identified as part of the 3 multi-disciplinary core teams hence the tracking of their training participation was not captured accurately and resulted in a gap in reporting capability. The intent is to leverage the clinical consultant to ensure that these staff members are identified and the training requirements are publicized, encouraged and tracked.

B1-8e. Monthly Case Conference Schedule

Although there are 38 total B1 primary care and behavioral health practices within IDN-3, below identifies the only 3 practices with MDCTs and for whom case management meeting cadence is in place. With the expected onboarding of a clinical consultant in July '19, the anticipated regional MDCT is intended to provide a monthly meeting outlet for all IDN member partners to participate in as requested.

MDCT Team #	Proposed IDN Provider Practices with Multi-Disciplinary Core Team (MDCT)	Case Management Meeting Schedule
1	**Dartmouth Hitchcock (DH) Practices**	
	DH Nashua Family Medicine	weekly - Tuesdays
2	**InteGreat Health (co-located between Lamprey Health and GNMHC)**	twice weekly – Mondays & Wednesdays
3	**Lamprey Health**	monthly - 1st Monday

B1-8f. Direct Secure Messaging

Progress

During this reporting period, the IDN completed a sponsorship agreement with [redacted] which has simplified the process for our partners in acquiring DSM capabilities through [redacted] 14 of our partners now have DSM capabilities through [redacted] which is a minimum capability/ standard for the ability to transmit patient information between providers. As part of the sponsorship on-boarding process, the IDN provided 1 Administrative and 2 User training opportunities for all of our [redacted] partners regardless of whether they acquired [redacted] as part of the sponsorship or not. All of the trainings were videotaped and are available to our partners for reference at any time.

For those partners with EHR systems and have Integrated DSM capabilities, the IDN is working with each of these partners to validate they are able to externally receive and send messages between their integrated DSM environment and our [redacted] partners by testing with their integrated DSM ID's and the IDN's [redacted] ID. Through this validation process, our partners are identifying and addressing small issues in order to completely operationalize this process. Some partners did not have operationalized process in being able to send/receive externally to another vendor DSM ID such as [redacted] Once this testing is complete and the IDN has attestations from all of our [redacted] partners of their DSM ID's they would like to use to exchange patient related data amongst all of the IDN partners, the IDN intends to publish annually, a directory of partner DSM IDs. This should help to facilitate usage and operationalization of this capability and less usage of technology like faxing.

Barriers/Challenges and Mitigation Plans

Issue: [redacted] Pricing Model Change: We were notified in late Q3 of 2018 that the pricing model had changed for [redacted] from what was budgeted for the entire waiver period based on NHHIO licensing which expired end of June of 2018. We worked closely with [redacted] the Data/IT Governance Committee Chair and Finance Committee to put in place a new IDN 3 Sponsorship agreement to cover up to 15 additional [redacted] providers. This was not approved until 04/2019 which delayed on boarding completion for some of our partners until later in Q2 of 2019.

Mitigation plan: A sponsorship agreement greatly simplified the on-boarding process for our partners and we were able to get a batch of folks on-boarded at the same time which also saved time and effort for the IDN.

Issue: Workflow change concerns: Partners have expressed concerns about adding a new tool to their existing workflow and want some assurance that other partners within the IDN will also acquire [redacted] for interoperability before impacting their workflows.

Mitigation plan: To ease some of these concerns, the IDN is in the process of publishing a DSM provider directory with DSM ID's each partner has provided the IDN to be distributed to all of our IDN members. This is activity is also part of the validation process mentioned above.

B1-8g. Closed Loop Referrals Narrative

Progress

The IDN Closed Loop Referral was part of the distributed recommended protocols to our partners who are in the process of providing attestation in their status to achievement. Based on the approved guidelines, a closed loop is considered complete once the patient/client is seen by the receiving provider and the receiving provider sends one or more or the following to the referring provider within one week of the appointment:

- "Confirmation of attendance" and/or
- "Patient engaged in treatment" and/or
- "Needs further referral"
- "Not eligible for state supported services"

The recommended guidelines allows for those referrals which may require a significant amount of time to complete the process or may need case management or care coordination, such as some of the social determinant of health areas (housing, legal, etc.), to have provider specific work flows and timeline definitions.

Most B1 partners are in the process of reviewing the IDN-3 recommended guidelines & protocols, inclusive of closed loop referral with Lamprey Health the only provider thus far to attest to meeting all the criteria to be considered closed loop. There is anticipation that other organizations likely meet the requirements of closed loop referral but with delays in receipt of the crosswalk of their organization documents to the IDN-3 approved guidelines & protocols, this is an unknown at this point.

Barriers/Challenges and Mitigation Plans

As noted below in B1-8h, Documented Workflows and/or Protocols in Use and Under Development, all B1 member partners have the IDN-3 approved documentation in hand with the IDN-3 Admin team

awaiting final review/attestation from 4 of 6 partners. Included in these workflows/protocols are the closed loop referral requirements hence the dependency on sign-off to confirm implementation/operationalization of a closed loop process. The mitigation, as noted below, is for the partner liaisons to continue to provide support as well as press for prioritization of this review. Additionally, with the Admin team clinical consultant anticipated to come on board in late July, this will be a priority area of focus.

B1-8h. Documented Workflows and/or Protocols in Use and Under Development

See attachment_B1.8hi for IDN-3 Guidelines & Protocols

Progress

The IDN-3 guidelines and protocols were developed by a working team comprised of clinicians from several IDN partners including Dartmouth Hitchcock, Lamprey Health and Greater Nashua Mental Health. These guidelines include:

- Interactions between providers and community based organizations
- Timely communications
- Coordination among case managers internal and external
- Safe transitions from institutional settings back to primary care, BH and social support service providers
- Intake procedures that include systematically soliciting patient consent to confidentially share information among providers
- Adherence to NH Board of Medicine guidelines on opioid prescribing

This team began by leveraging documentation from other regions and after several working sessions, came to consensus and developed the IDN-3 guidelines. These guidelines were provided to the Clinical Governance committee, were reviewed, and agreed upon in May. Shortly thereafter, the guidelines and protocols were distributed to the 6 B1 primary care and behavioral health treatment partner points of contact:

- Dartmouth Hitchcock
- Foundation Medical Partners
- Greater Nashua Mental Health
- Lamprey Health
- The Emmaus Institute
- The Youth Council

These organizations were asked to review the recommended guidelines, compare to their existing protocols, sign-off on those already in place, identify where there were gaps in existing documentation and document what the mitigation plan/timeline was to complete. As of the end of this reporting period, Greater Nashua Mental Health and Lamprey Health were the only B1 partners to respond via attesting to existence of all required guidelines and protocols (GNMH has a plan in place/timeline for 2 items in flight scheduled to be complete by 9/30/19).

Barriers/Challenges and Mitigation Plans

With the expectation that all IDN-3 B1 primary care and behavioral health treatment partners have these guidelines and protocols documented and operationalized, there is delay in receipt of attestation status from 4 of the 6 partners. Not having visibility to the status of the degree of operationalization, nor confirmation of documentation of these guidelines, leaves a gap in ability to sign-off on the meeting of this requirement. IDN-3 partner liaisons are working closely with their partner points of contact to provide visibility and confirmation of status.

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: • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment	CCSAs (Submit all that are in use) Table listing all providers by domain indicating Y/N on progress for each process detail				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	• Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT					
	For pediatric providers, the CCSA must also include: • Validated developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; • Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental	Table listing all providers by domain indicating Y/N on progress for each process detail				
B1-8b	List of multi-disciplinary core team members that includes, at minimum: • PCPs • Behavioral health providers (including a psychiatrist) • Assigned care managers or community health worker	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	Multi-disciplinary core team training for service providers on	Training schedule and Table listing all provider				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	topics that includes, at minimum: • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple)	practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	Documented work flows and/or protocols	Work flows and/or Protocols				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	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 • Intake procedures that include systematically soliciting patient consent to confidentially share information among providers • Adherence to NH Board of Medicine guidelines on opioid prescribing	(submit all in use)				

B1-9a. Achievement of all requirements of a Coordinated Care Practice

See attachment_B1.2b: Narrative Guidance

Progress made towards Coordinated Care practice designation, by partner, is noted in detail in the narrative guidance attachment. In summary, no partner achieved Coordinated Care designation during this reporting period. While IDN-3 member partners have had notable progress with CCSA implementation and operationalization, implementation of Direct Secure Messaging, movement towards attestation of guidance and protocol documentation, none have secured all of the requirements to achieve Coordinated Care designation.

B1-9b. Additional Integration Care Practice designation requirements

See attachment_B1.2b: Narrative Guidance

Although no IDN-3 member partners have even achieved Coordinated Care designation, hence unable to declare success at achievement of Integrated Care designation, several, inclusive of Dartmouth Hitchcock and Foundation Medical Partners, are moving forward on the continuum via actively implementing Medication-assisted treatment (MAT) services. Dartmouth is on target to go live in September within their Family Medicine practice and have made significant progress with several primary care physicians having been waivered. Their team has finalized toolkits, workflows and the associated protocols in preparation for the launch and is now actively engaging their staff in various trainings including minimizing stigma. On the other hand, Foundation Medical Partners, will be implementing a dedicated MAT clinic within an existing campus with renovations underway and an anticipated opening by the end of July. The clinical will be open Monday through Friday with a Patient Service Representative or Medical Assistant / Receptionist and a nurse care coordinator available at all times. There will be a Masters Licensed Alcohol and Drug Counselor (MLADC), LICSW or LCMHC available during clinic hours. During ramp up, the clinic will have one (4) hour provider session per day, 3-5 days per week, with the goal of full-time coverage (5) days per week, with provider sessions expanding based on patient need. Services will be by appointment only. This is not a walk in clinic. To date, 6 prescribers have been waivered and targets have been set over the next 3 years for patient participation rates.

B1-9c. Use of Technology

See attachment_B1.9c IDN Member Entity Provider Use of Technology

B1-9d. Documented Workflows or Protocols under Development with Community-Based Social Support Service Protocols

See attachment_B1.8hi for IDN-3 Guidelines & Protocols

Progress

These Community-Based Social Support Service Protocols, inclusive of joint service protocols and communication channels, were included in the work noted above on “Documented Workflows and/or Protocols in Use and Under Development”, completed by the clinical working team from Dartmouth Hitchcock, Lamprey Health and Greater Nashua Mental Health, approved by the Clinical Governance committee and distributed to all 6 B1 primary care and behavioral health treatment providers (Dartmouth Hitchcock, Foundation Medical Partners, Greater Nashua Mental Health, Lamprey Health, The Emmaus Institute, The Youth Council). Similarly Greater Nashua Mental Health and Lamprey Health are the only

IDN-3 partners to have attested to their operationalization thus far.

Barriers/Challenges and Mitigation Plans

With IDN-3's recommended Community-Based Social Support Service Protocols finalized and distributed the expectation is that all IDN-3 partners will share their practice's versions or attest to their existence and operationalization.

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: • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	Protocols (Submit all in use)				
• B1-9c	•	• Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	• Table listing all providers indicating progress on each process detail				
B1-9d		Documented work flows with community based social support	Work flows (Submit all in use)				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		service providers including, at minimum: • Joint service protocols • Communication channels					

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

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

Achieved	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18	Number Designated 6/30/19
Coordinated Care Practice	39	0	~~1~~ 0	~~1~~ 0	0	0
Integrated Care Practice	2	0	0	0	0	0

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	12/31/18	6/30/19
	Dartmouth Hitchcock (DH): Nashua Family Medicine DH: Nashua Internal Medicine DH: Hudson DH: Merrimack DH: Milford DH: Nashua Pediatrics Foundation Medical Partners (FMP): Amherst Family Practice FMP: Downtown Medical Associates FMP: Hudson Family Practice FMP: Milford Family Practice FMP: South Nashua Family Practice FMP: Internal Medicine Associates of Nashua FMP: Merrimack Medical Center FMP: Nashua Primary Care FMP: Nashua West Adult Medicine FMP: Pelham Family Medicine FMP: Internal Medicine at Pelham Medical Center FMP: Medicine-Pediatrics of Nashua FMP: Foundation Pediatrics FMP: Main Street Pediatrics and Adolescent Medicine FMP: Internal Medicine Greater Nashua Mental Health Harbor Homes	**Not Achieved** No providers achieved Coordinated Care designation	**Not Achieved** No providers achieved Coordinated Care designation

	Healthy at Home Keystone Hall ~~LaMora Psychological Associates~~ Lamprey Health Merrimack River Medical Services St. Joseph Hospital & Physician Practices (SJH): Pediatrics Nashua SJH: Pediatrics Milford SJH: Pediatrics Sky Meadow SJH: Family Medicine, Nashua SJH: Internal Medicine SJH: Family Medicine and Specialty Services Hudson SJH: Family Medicine and Specialty Services Merrimack SJH: Family Medicine and Specialty Services Milford SJH: Adult Medicine The Emmaus Institute The Youth Council		

Progress Toward Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/18	6/30/19
	Dartmouth Hitchcock (DH): Nashua Family Medicine DH: Nashua Internal Medicine DH: Hudson DH Merrimack DH: Milford DH: Nashua Pediatrics Foundation Medical Partners (FMP): Amherst Family Practice FMP: Downtown Medical Associates FMP: Hudson Family Practice FMP: Milford Family Practice FMP: South Nashua Family Practice FMP: Internal Medicine Associates of Nashua FMP: Merrimack Medical Center FMP: Nashua Primary Care FMP: Nashua West Adult Medicine FMP: Pelham Family Medicine FMP: Internal Medicine at Pelham Medical Center FMP: Medicine-Pediatrics of Nashua FMP: Foundation Pediatrics FMP: Main Street Pediatrics and Adolescent Medicine FMP: Internal Medicine Greater Nashua Mental Health Harbor Homes	**Not Achieved** No providers achieved Integrated Care designation	**Not Achieved** No providers achieved Integrated Care designation

	Healthy at Home Keystone Hall ~~LaMora Psychological Associates~~ Lamprey Health Merrimack River Medical Services St. Joseph Hospital & Physician Practices (SJH): Pediatrics Nashua SJH: Pediatrics Milford SJH: Pediatrics Sky Meadow SJH: Family Medicine, Nashua SJH: Internal Medicine SJH: Family Medicine and Specialty Services Hudson SJH: Family Medicine and Specialty Services Merrimack SJH: Family Medicine and Specialty Services Milford SJH: Adult Medicine The Emmaus Institute The Youth Council		

Projects C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

See attachment_C.1a: IDN Community Project Implementation Plan

The Critical Time Intervention (CTI) strategy and workforce fall under the umbrella of the Greater Nashua Mental Health Center. The transition selected by the IDN Clinical Governance Committee for the C1 implementation plan was transitions out of the region's emergency departments (Southern NH Medical Center and St. Joseph Hospital) and inpatient hospitalizations (Southern NH Medical Center, St. Joseph Hospital, SNHMC Behavioral Health Unit, NH Hospital, and the state's Designated Receiving Facilities).

Target Population: Number of Individuals Served vs. Projected

Progress

The Critical Time Intervention (CTI) strategy focuses on those adult clients 18 years of age and older diagnosed with a primary Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI). While it was determined that the CTI team would not serve individuals with a primary diagnosis of an intellectual/developmental disability, substance use disorder, or personality disorder, there was a recognition that there may be special cases where it may be appropriate to serve individuals with these diagnoses.

With the cases involving those with an intellectual/developmental disability, Gateways Community Services has been contracted through IDN funding to provide clinical case management consultation to support the CTI team, especially for those clients experiencing numerous visits to the Emergency Department and meeting the criteria for CTI otherwise. Since program start there have been 3 clients with an intellectual/developmental disability enrolled in the program, 2 of which were in the program within the period of January to June 2019. Two clients were referred to Gateways and one to the Moore Center where the client previously received services.

Additionally, for those clients expressing a desire to engage with more spirituality-based therapeutic interventions, The Emmaus Institute has been contracted through IDN funding to provide clinical case management consultation and support services. The CTI team had contact with the Emmaus Institute regarding 2 clients from January to June of 2019. All CTI staff attended a training entitled Spirituality in Behavioral Health Patient Care: An Introduction: in June offered by the Emmaus Institute to assist with identifying clients that might benefit from referral and to address spiritual needs even when a referral is unable to be made.

Additional criteria for eligibility for CTI include those not already receiving adequate mental health services and self-reporting having at least areas of need, which are included in their goals over the following 6 – 9 months. In the table below, the total number of clients identifying each of the 6 main areas of need as a goal are listed, along with a few other significant areas of identified need (even when clients may not have chosen to work on that as part of their phase plans). Please note that clients may be counted multiple times since their plans may include multiple focus areas and over their 6-9 months in the program new areas might be identified when phase plans are updated every 3 months. Over the course of the program, assistance with connecting to behavioral health services is the most requested, followed by

connecting to medical services. Assistance with independent living skills is the least requested despite many clients identifying needs with financial management and transportation. The CTI team is using this data to determine areas where stronger connections with other community-based services are needed.

Areas of Focus Identified by CTI Clients
January 2018 – June 2019

Identified Focus Areas in CTI Phase Plan	Number of CTI Clients Requesting to Have Goal on Phase Plan Jan-Jun 2019	Total CTI Clients since Program Start
*Behavioral Health All (SUD)	26 (5)	63 (13)
*Medical Health	20	41
*Housing	13	35
*Income, Employment & Finances	8	20
*Family & Social Supports	7	18
*Independent Living Skills	2	7
Identified Need	**Number of CTI Clients with Identified Need Jan-Jun 2019**	**Total CTI Clients since Program Start**
Does not have Medicaid	8	15
Homeless or at risk of homeless	14	35
Unemployed/under employed	7	22
Managing money	12	27
Transportation	12	27

For the time frame of January – June 2019, the program averaged between 27 and 35 clients per month, with a total number of unduplicated clients served in the period of 50. There have been 76 clients enrolled in the program since it began. The breakdown of the clients served to date by demographics are outlined in the table below.

CTI Enrollment
January 2018 – June 2019

	Jan – Jun '18	July - Dec '18	Jan '19	Feb '19	Mar '19	April '19	May '19	Jun '19	Jan – Jun '19
Total Enrolled	24	36	22	24	24	33	32	29	50
# of referrals received	44	36	4	9	8	8	6	5	40
# of new enrollments	24	23	1	6	6	7	4	3	27
# declined to participate	20 Total; Numbers Not Tracked Separately	13 Total; Numbers Not Tracked Separately	2	0	1	0	0	0	3
# determined not eligible			1	3	1	1	2	2	10
# discharged	11	13	3	1	1	4	6	5	20
# of discharged who completed/graduated	1	6	3	1	1	4	5	4	18
Gender: F	9	24	17	16	16	17	16	14	29
Gender: M	15	12	5	8	8	16	16	15	21
Age: 18 – 27	9	8	6	8	8	11	11	10	15
Age: 28 – 37	5	6	5	7	6	9	8	6	12
Age: 38 – 47	4	7	3	3	4	5	4	3	8
Age: 48 – 57	2	8	5	3	4	6	8	7	10
Age: 58 – 68	4	7	3	3	2	2	1	3	5
Race: Asian	0	1	1	1	2	2	2	1	2
Race: Black/African American	0	0	0	0	0	0	1	1	1
Race: White	18	23	15	17	11	17	15	16	30
Race: Two or More	1	4	2	2	2	2	1	1	2
Race: Not Disclosed	5	8	4	4	9	12	13	10	15

Barriers/Challenges and Mitigation Plans

With the CTI program encompassing approximately 9 months per client, the program's target was to serve 80 to 100 clients annually after the initial implementation period of ramp up during which it was expected to take on 25 to 30 clients per 3 month period to allow an even number of clients across the 3 month long phases. Per the program's fidelity, the team could have a maximum caseload of approximately 60 cases at a time if it was staffed as originally budgeted and depending upon the level of intervention clients receive at the time.

Since January 2018, 76 clients have enrolled in CTI, with 29 enrolled as of the end of June 2019. This lower-than-expected enrollment is due to various factors. The program was designed as a program to assist clients transitioning from an Emergency Room or inpatient admission. It was expected that referrals would come from both hospitals in the IDN region, however no referrals have been received from St. Joseph's Hospital to date despite many attempts to educate their staff about the program and referral process. In

addition, though referrals have been received from various hospitals across the state following inpatient hospitalization, the referrals from Emergency Rooms were less than anticipated. This is partially due to a planned IDN supported position within St Joseph's Hospital Emergency Room not being implemented. Also, many clients in Emergency Rooms were found not eligible for the program as a result of not having Medicaid or being at risk of Medicaid. Since the referrals were less than expected, GNMH has yet to fill a budgeted .5FTE CTI Specialist position. With the current staffing pattern and without this position in place, the maximum number of clients the program can enroll at a given time is 55. In addition, because there were less referrals from local partners, the CTI team reached out to hospitals across the state for referrals of individuals who live in our region but were hospitalized elsewhere, especially during the first year of the program. While this helped increase the number of referrals, it decreased the maximum number of clients a CTI Specialist could effectively manage since the Specialists were now traveling out of the region to provide education about the program, complete assessments and engage in pre-CTI, which increased travel time and decreased time available to clients. Lastly, the team has found that clients have required significantly more services in initial phases than anticipated, especially those who are homeless, without insurance at the time of referral, or have limited English proficiency.

GNMH is working with the IDN to identify strategies to enroll more clients. To achieve this goal, the team has been working closely with the behavioral health staff of Southern New Hampshire Health (SNHH), the source of most referrals. To increase collaboration between the teams, during the month of June, CTI Specialists began visiting the Behavioral Health Unit (BHU) 4 to 5 days a week to review any possible referrals to the program. At the outset of the program, the CTI program only accepted clients from the Emergency Room or BHU of the hospital. Due to this increased collaboration, the CTI team also began accepting referrals from the Partial Hospital Program (PHP) at Southern New Hampshire. If referrals from the various programs of SNNHH continue to increase, GNMH will work to hire for the currently pended .5FTE CTI Specialist position and consider, in collaboration with SNHH, having a CTI Specialist at the BHU/PHP building daily for a specific number of hours.

GNMH is also working alongside the IDN Lead to increase the engagement of St Joseph's Hospital in IDN activities. It is unlikely that there have been no eligible clients in their Emergency Room since the start of the project, which means that there have been eligible clients who have not benefited from the services the CTI Team provides.

Workforce: Recruitment/Hiring, Retention and Training

Staff recruitment/hiring and retention:

The CTI team is housed under the umbrella of Greater Nashua Mental Health, the community mental health center serving IDN 3. At the onset of the program in late 2017, initial target staffing for the team included:

- Coordinator/Team Lead: 1 FTE
- CTI Specialist/Case Manager: 2.5 FTEs

Based upon lessons learned in the first year of the pilot, the need for increased clinical supervision in the field from a licensed mental health clinician was identified. Therefore, GNMH requested an additional .15 FTEs from the IDN to support a Clinical Supervisor, who filled this position from April 2018 - present. The CTI team lead (Coordinator) left the program in early 2018, with the Clinical Supervisor taking on that gap through February 2019, when one of the current CTI Specialists took over the role of Coordinator and a new Specialist was hired.

This change from using a Master's level Coordinator who served as both the clinical supervisor and

coordinator to having a Field Coordinator and Clinical Supervisor, increased the total staffing by .15FTE and the maximum number of clients that can be served at a time by when fully staffed from 60 to 65 clients. The current budgeted positions are:

- Clinical Supervisor (Licensed Therapist): .15 FTEs
- Team Lead/Field Coordinator: 1 FTE
- CTI Specialist: 2.5 FTEs.

As of June 2019, the CTI team included the following roles and FTEs:

- Clinical Supervisor (Licensed Therapist): .15 FTEs
- Team Lead/Field Coordinator: 1 FTE
- CTI Specialist: 2 FTEs.

The remaining CTI Specialist (.5 FTEs) role approved for IDN funding has not been on-boarded to date, as the team has determined there is currently not a need to fill that position until referrals increase for the program. Should an increase in referrals from SNHH be observed in the next quarter, GNMH and SNNH will work collaboratively to determine if the additional .5 FTE could be used to place a CTI Specialist within the SNHH system. A decision about if this plan should be implemented is expected by September 30, 2019.

The Clinical Supervisor (also serving as the CTI Coordinator from April 2018 – January 2019) has been retained with the program since its onset in late 2017. One of the Specialists was on-boarded in November 2017 and has been retained, with the other Specialist (now the Coordinator as of February 2019) on-boarding in January 2018 and also remaining retained to date. The final Specialist currently on staff was on-boarded in February 2019.

Staff training:

The team has continued to engage with [redacted] funded through IDN 3, along with the other 4 IDNs implementing the CTI strategy across the state. The CTI team has participated in the Community of Practice (CoP), including monthly (1-hour) webinars and quarterly (3-hour) in-person sessions with the other CTI pilot programs across the state.

During this reporting period, a CTI Supervisor training was conducted, with the newly on-boarded CTI Coordinator participating. Other training/professional development completed by the CTI team from IDN offerings or other outside organizations included:

- Suicide Risk Assessment: February
- Narcan Training: February & March
- Chronic Disease Management for Behavioral Health Providers: March
- Mental Health First Aid: March
- Use of the [redacted] PreManage platform for ENS: April
- Mental Health Awareness (IDN2 Presentation): June
- Spirituality in Behavioral Health Patient Care: An Introduction: June

In addition to the Community of Practice and formal trainings, [redacted] was available to the CTI team for up to 5 hours of one-on-one technical assistance. During the reporting period, this technical assistance was not utilized. Technical assistance coaching is scheduled in the coming months around the scheduled CTI Fidelity Training in July.

Clinical Services Infrastructure Implementation: Standardized Assessment and Protocols/Workflows

Progress

Referrals into CTI include information provided in the CTI Referral Form, which supports the referring organization's determination for whether or not the client may be a good candidate for the program. This includes:

- The individual's primary mental health diagnosis and age (18 years old and older)
- A resident of one of the 13 communities in the IDN 3 region
- The need for case management to address unmet needs, including:
  - Housing
  - Mental health/substance use treatment
  - Economic/job skills
  - Family/social supports
  - Money management
  - Independent living

The referral source connects with the CTI Coordinator for the referral and ideally, the CTI team would be engaged prior to discharge to allow the client to engage with the CTI Specialist in the Pre-CTI Phase. Below is a summary of referral sources for the CTI program by month.

Referrals into CTI by Source
January 2018 – June 2019

	NH Hospital	SNHMC ED	SJH ED	SNHMC BHU	SNHMC PHP	DRF: Elliot	DRF: Portsmouth	DRF: Cypress	DRF: Franklin	Other	Total Referrals
Jan - June 2018	2	1	0	7	0	0	0	1	0	5	16
July - Dec 2018	3	0	0	21	0	0	0	0	0	10	38
Jan'19	0	2	0	2	0	0	0	0	0	0	4
Feb'19	2	1	0	6	0	0	0	0	0	0	9
Mar'19	1	2	0	5	0	0	0	0	0	0	8
Apr'19	0	0	0	8	0	0	0	0	0	0	8
May'19	0	0	0	3	2	1	0	0	0	0	6
Jun'19	0	0	0	3	2	0	0	0	0	0	5

Those referrals into CTI from the "Other" category are outlined below:

- GNMH ACS: 3
- Dartmouth Hitchcock: 2
- Harbor Homes Mobile Crisis Unit: 9
- Holy Family: 1

After referral is reviewed and client is determined to be a good candidate for CTI, a CTI Assessment is completed by a member of the team to more fully determine eligibility and to obtain consent to join the program. As part of this intake process, information is collected as the basis of the client's plan, including:

- Identifying the individual's presenting problem
- Identifying the individual's needs and strengths
- Determining the presence of a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission

- Obtaining a pertinent social, family, and medical history and
- Need for referral to clinical supervisor to assess need for other evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the individual's needs.

If not appropriate for CTI services or if the client declines to participate, the client is referred to appropriate providers, following the IDN Guidelines for closed loop referrals. For the 13 clients not enrolled in CTI during the January to June 2019 period:

- 4 had Medicare or other commercial insurance coverage
- 3 clients refused to participate, and
- 7 clients were deemed inappropriate for CTI level services, due to discharging to a location out of region, not having functional impairments, or enrolled in or referred to other more appropriate behavioral health service.

For those clients not enrolled in CTI, they were referred to the following provider organizations:

- GNMH's Acute Care Services or Intake Teams for further evaluation
- Other Community Mental Health Centers in New Hampshire or other states.

Ideally, the CTI team will receive referrals from providers prior to discharge from the hospital or emergency department. This allows for continuity of care and reduces the incidences of clients not being found or refusing participation in the program. Of the 41 referrals received during the reporting period, 31 came from a total of 3 hospitals. This allowed for increased ability for the CTI Assessment to be completed while the client was in the hospital or emergency department and for 9 clients to benefit from pre-CTI.

Once the CTI Brief Assessment is completed, the Specialist works with the client to identify the 3 focus areas and goals mutually agreed to that will serve as the case management plan the CTI team will support over the next 6 – 9 months. The CTI Specialist also develops a crisis plan with each CTI client to ensure they know their available resources and supports to help avoid the inappropriate use of the emergency department.

Throughout the CTI model, the CTI Specialist works with the client to make active referrals, ensuring a closed loop to support care management and coordination. This includes the connections with their primary care physician and mental health provider (or assist them in finding one, if they are lacking one) while developing and implementing a transition plan, as well as other services to support the client's mutually agreed upon goals. Emotional support is consistently provided in moving the client toward more self-sufficiency.

For clients who enter the program with a PCP, an ROI is obtained and linkage is confirmed or reestablished. For those without a PCP, linkage is made through a closed loop referral process. All but 4 of the clients enrolled in the program in June of 2019 are connected to a PCP. Linkages this reporting period were made to:

- Harbor Homes (FQHC)
- Lamprey Health Care
- St Joseph's Family Medical Partners
- Dartmouth Hitchcock and
- Foundation Medical Partners.

For those in need of a mental health provider and enrolled with GNMH for those services, the CCSA process is conducted, following the IDN 3 Guidelines, with the results serving as the basis of the client's

individualized care plan. For those clients receiving their mental health services from other providers, the CCSA process is completed with organizations. To date, 47 CTI clients have completed the CCSA process.

For those clients being served by or referred to IDN partners, case management meetings are held to share information relevant to the ongoing care and identified goals of the client. During this reporting period, case management meetings were held with:

- Gateways Community Services: 1
- HEARTS Peer Support and Respite Care: 6
- Lamprey Health Care: 3
- Life Coping: 1
- Revive Recovery Center: 6
- Southern NH Medical Center Behavioral Health Unit: Multiple times per week, as needed
- The Emmaus Institute: 2
- Other Area Agency (Moore Center/Easter Seals): 2
- The Front Door Agency: 5
- Other programs at GNMH: Multiple times per week, as needed.

This reporting period CTI staff began receiving notification through direct secure messaging (DSM) and the [redacted] PreManage platform ([redacted] of hospitalizations and emergency departments visits of their clients (i.e., Event Notification). This allows the staff to rapidly respond to psychiatric or heath needs that contributed to the hospital or emergency department visit to promote care coordination and ongoing treatment planning.

The CTI Team is aware of the IDN goal of using [redacted] to create shared care plans (SCP) by entering information that other agencies also providing services to a client would be able to access. To date, no CTI clients have been part of an electronic shared care plan through [redacted] The barriers to implementation are primarily related to agency concerns about confidentiality of behavioral health and substance use disorder information. Throughout this reporting period, the agency has engaged in multiple meetings with the goal of either adequately addressing the confidentiality concerns or creating alternatives that will be in compliance with IDN guidelines.

Barriers/Challenges and Mitigation Plans

As mentioned above, the CTI Team and others at GNMH are actively engaged in efforts to increase referrals to the program. There has been increased collaboration with SNNH this period resulting in referrals from the PHP Program and potential plans to utilize the remaining budgeted .5 FTE to ensure care coordination and shared care planning. A decision about this is expected by September 30, 2019. In addition, the CTI team will continue it's at least every other month outreach to other area hospitals and designated receiving facilities to provide information about referral process.

With the increase of meetings involving IDN, [redacted] and GNMH staff, it is expected that there will be resolution in the next reporting period to confidentiality concerns.

Evaluation and Program Impact

Progress

As outlined in the C1 Evaluation Targets table and in the SFY '19 IDN Sub-contract Scope of Work executed with, progress in the achievement of process and outcome targets is outlined below.

1. Target enrollments and completion of program ("graduation"):

The target enrollment for the July 2018 – June 2019 (SFY '19) time frame was a minimum of 50 clients, with up to 25 clients completing the full 9-month program. As of June 2019, CTI has enrolled 76 clients. Forty-four (44) clients have been discharged to date, of whom 25 (57%) completed the program by transferring to a more appropriate program (e.g., ACT) or graduating. In the beginning of the program there were proportionately more non-completers (i.e., 9% of discharges were completers Jan-Jun 2018, 46% were completers July-Dec 2018, and 90% were completers Jan-Jun 2019). One main contributing factor to non-completion has been moving out of the area to obtain housing. A closed loop referral process confirming that the client was enrolled in appropriate care coordination services upon moving out of area is a requirement to consider the discharge complete. With training and improvement in workflows, the ability to confirm linkage has improved over the course of the project.

2. Increased knowledge/skills among the CTI team to work with the target population:

The team has continued its engagement with [redacted] (along with the other 4 IDNs implementing CTI) during this reporting period. This has included participating in the monthly Community of Practice (CoP), training opportunities, and one-on-one technical assistance.

- Community of Practice (CoP):
  - monthly 1-hour calls and quarterly 3-hour in-person sessions, focusing on sharing of lessons learned and strategizing on barriers/challenges, as well as planning for sustainability.

- Training (staff- and supervisor-specific):
  - The newly on-boarded CTI Team Lead/Coordinator (moving from a Specialist role) participated in a full-day CTI Supervisor training conducted in May (see attachment_C.9b: CTI Supervisor Training Agenda).

- One-on-one technical assistance/implementation coaching (up to 5 hours)
  - This was pended this period and is scheduled to support following the Fidelity Training scheduled in July.

- Fidelity assessment and monitoring of the fidelity action plan:
  - Baseline fidelity assessment completed in November 2018 with a score of 3.73 ("well implemented") out of 5
  - The implementation plan was successful in obtaining the goal of a well implemented program. Ongoing engagement in the Community of Practice and training, along with a specific training in fidelity scheduled for July and follow up coaching with [redacted] will ensure maintenance of "well" implementation achievement. Achievement of "ideal" implementation (score of 4.5-5) is desired prior to the end of the demonstration.

Additionally, the team has engaged in several IDN-provided trainings, as well as outside training/professional development opportunities:

- IDN-provided trainings:
  - Mental Health First Aid (MHFA): March
  - Chronic Disease Management for Behavioral Health Providers: March

- Outside trainings/professional development opportunities:
  - Suicide Risk Assessment: February
  - Narcan Training: February & March
  - Use of the [redacted] PreManage platform for ENS: April

- Use of Direct Secure Messaging: April
- Mental Health Awareness (IDN2 Presentation): June
- Spirituality in Behavioral Health Patient Care: An Introduction: June

Other goals for increasing knowledge of the CTI team included working to improve referral protocols to be tracked electronically and to include closed loop referrals, as indicated. As part of their on-boarding all staff receive training in GNMH protocols related to closed loop referrals and their documentation in our EHR. At this time, there is no other identified electronic system to coordinate closed loop referrals.

3. Increase in the capacity of IDN providers to support the transitions of the target sub-population from hospital settings to the community:

Being trained in the use of HIT tools and data associated with ENS through the use of Direct Secure Messaging (DSM) and the [redacted] platforms to ensure data collection and monitoring is valid and reliable was another goal for this reporting period. In April, an internal training was conducted with all staff at GNMH, including the CTI team, to outline the new capability for the organization now that contracting and sharing of eligible patient files had been completed in January of 2019 with [redacted] This new workflow allows for the timely notification of admissions, discharges and transfers (ADTs) for all hospital emergency department and inpatient visits completed by GNMC clients, including those enrolled in CTI.

GNMH is currently engaged in conversations with [redacted] to address confidentiality concerns related to using the platform for shared care planning. GNMH is actively engaged in conversations to piloting a process with the IDN-funded SUD Transitional Care Coordinator and staff at the Behavioral Health Unit at SNHMC using DSM and other methods to ensure that important information is shared and received with consent protocols and workflows to allow the editing/addition of information to the visit summaries.

4. Increased knowledge and skills of the IDN's resources to support the physical and mental health of clients, as well as those that support the social determinants of health, including economic, legal, educational and social, as well as housing and transportation:

Now that GNMH has on-boarded with [redacted] and staff have been trained in the workflows and protocols when receiving notifications of emergency department and inpatient visits, the Coordinator and Specialists are tracking and monitoring this activity for their clients, allowing for timely follow-up upon admission and/or discharge to support the client.
Case management/community care team meetings with IDN partners who are also engaged in a client's care have been ongoing the reporting period. To date, meetings were held with The Emmaus Institute, Life Coping, Gateways Community Services, HEARTS Peer Support and Respite Care, Lamprey Health Care, Revive Recovery Center, Southern NH Medical Center Behavioral Health Unit, other Area Agencies (Moore Center/Easter Seals), The Front Door Agency, and other programs within the Greater Nashua Mental Health. Unfortunately, to date meetings have generally been with one provider and the CTI team staff rather than with multiple providers. The CTI staff would welcome the opportunity to join a regional multi-agency team meeting if coordination with other entities can be facilitated.

5. Increased use of supports identified in the client's crisis management plan for the client to utilize in situations when they need assistance to avoid hospital-related visits for non-emergency reasons:

The CTI team uses multiple strategies to support clients in seeking alternatives to visiting the hospital for non-emergency reason. Staff are trained in closed loop referral and set primary goals of linking clients to primary care and behavioral health providers. With the on-boarding of Event Notification through DSM and [redacted] in in January of 2019, CTI staff had accurate and timely information about their client's visits to

emergency departments and inpatient admissions. The increased knowledge about visits to hospitals, including emergency departments and inpatient units, provides an opportunity for more timely follow-up and re-examination of the crisis management plan created to support the client's decision-making about where to go for services and what supports are in place to avoid unnecessary hospital visits.

Of the 50 enrolled CTI clients during the reporting period, 11 had a visit to the emergency department. It is outside the scope of the agency's practice to determine if their visits were unavoidable. If the definition of visit the emergency department greater than 4 times is used, this would apply to 3 of 50 clients. Additionally, 1 of the 50 clients was readmitted to an inpatient setting within 30 days of discharge.

6. Timely connection to primary care physicians and mental health clinicians upon discharge from hospital/inpatient stay:

The IDN targets were for up to 80% of CTI clients confirmed as connected to a PCP by month 3 of the CTI program, with up to 95% by month 6. In this reporting period, 36 of 50 clients enrolled have a confirmed connection to a PCP.

One of the benefits of the CTI program is direct, closed loop linkage to behavioral health services upon admission to the program, rather that client needing to follow up on referrals themselves. Thus, it was expected that with this support, follow-through on initial behavioral health appointments would improve greater than 75%. Previous no show rates for initial appointments were 30.37%, they are now 9.21%.

CTI staff connect clients to behavioral health services upon admission into the program and provide support to and advocacy for clients who are re-hospitalized during their time in the program to connect with their behavioral health provider as soon as possible upon discharge. The CTI team does not track time from discharge to appointment with other providers, since the time is generally dependent on the provider. However, 71% of CTI clients for whom staff were aware of a re-hospitalization were seen by CTI staff within 7 days of their discharge.

7. Decrease in avoidable emergency department visits and inpatient hospitalization:

The IDN target was for a minimum of 75% reduction in avoidable ED visits. Of the 50 enrolled CTI clients during the reporting period, 11 had a visit to the emergency department. It is outside the scope of the agency's practice to determine if their visits were unavoidable. If the definition of visit the emergency department greater than 4 times is used, this would apply to 3 of 50 clients.

The IDN also had the goal of 75% reduction in readmission for inpatient hospitalization visits. During the reporting period, 1 of the 50 clients was readmitted to an inpatient setting within 30 days of discharge.

8. Increase in utilization of community-based services, such as housing assistance, legal assistance, family and support services, etc., with all CTI clients securing a stable housing plan, as applicable:

All CTI clients who enroll in the program develop an action plan to address needs, which generally includes being connected to a minimum of 2 services. CTI staff document contacts and closed loop referrals to community-based services per agency protocols and have had an increase in contacts and case management meetings with community-based services this reporting period.

Barriers/Challenges and Mitigation Plans

The CTI team has determined 3 factors, which when co-occurring, are the highest predictor of lack of engagement and readmission into the hospital or emergency department; being homeless, having no

phone, and having a Substance Use Disorder. This combination creates a context which makes it challenging for CTI staff to find clients once discharged from the hospital even though plans are made to connect at places such as the library. The combination is especially challenging because as one case recently highlighted, clients without an address are unable to obtain a Safelink phone and those with an addiction are often distracted from keeping appointments that they were told verbally but unable to confirm over the phone. Often the CTI team struggles to locate these clients until they are readmitted to the hospital or emergency department. The CTI team has recently engaged in conversation with the Integrated Dual Disorders Treatment Team to explore if these clients should be referred to their team straight from the hospital rather than to the CTI team first or how the 2 teams can work in closer collaboration when clients present with this combination of challenges.

C-2. IDN Community Project: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Client Engagement	Up to 10 clients are engaged in CTI in 2017, depending upon workforce recruitment, training timing and referral protocols being in place.	Achieved: 29 clients are currently engaged in the CTI strategy	Achieved in prior reporting period, with the program averaging between 22 and 33 clients per month, with a total number of unduplicated clients served in the period of 50.
Client Engagement	Up to 100 clients (up to 4 per month) are engaged in CTI annually 2018 - 2020, ensuring fidelity to model is met, with up to 24 by June 30, 2018.	Achieved: 66 referrals to date, with 29 currently enrolled and 2 graduating.	Achieved in prior reporting period, with 76 clients having been enrolled in the program to date.
Increased knowledge of screening tools to utilize to assess individuals with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) in the attributed subpopulation.	Up to 5 IDN clinical and/or behavioral health providers are trained in the available tools and techniques to assess appropriateness of attributed IDN patients participating in Critical Time Intervention (CTI) program strategies in the IDN by June 30, 2018.	Achieved: 3 CTI staff members were trained by [redacted] as part of the CTI Staff Training.	Achieved in prior reporting period, with all staff participating in ongoing community of practice calls/meetings, as well as attending ongoing trainings.
Increased knowledge of standard assessment, treatment and management protocols for patients with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) being discharged back into the community.	Up to 5 behavioral health providers are trained in the available tools to assess, treat and manage attributed IDN patients participating in Critical Time Intervention (CTI) strategy in the IDN by June 30, 2018.	Achieved: 3 CTI team members were trained by [redacted] as part of CTI Staff training.	Achieved in prior reporting period, all staff participating in ongoing community of practice calls/meetings, as well as attending ongoing trainings.
Increased knowledge of standard assessment, treatment and management protocols for patients with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) being discharged back into the community.	Up to 5 behavioral health providers are trained in the available tools to assess, treat and manage attributed IDN patients participating in Critical Time Intervention (CTI) strategy in the IDN by June 30, 2018.	Achieved: 2 CTI team members were trained as part of CTI Supervisor training in 2017/2018.	Achieved in prior reporting period, with 1 CTI team member being trained as part of the March 2019 CTI Supervisor Training.

Increased skills among CTI Specialists (Case Managers) to assess the needs of individuals with SMI/SPMI as they support them in becoming more self-sufficient in accessing the treatment and resources needed to sustain their health.	The CTI team engages in cross-learning among the 5 IDN regions conducting the CTI strategy through participating in monthly Community of Practice (CoP) sessions provided by [redacted]	Achieved: All CTI staff engaged in monthly CoP sessions via webinar, as well as the quarterly in-person sessions.	Achieved, with all CTI staff engaging in monthly CoP sessions via webinar, as well as the quarterly in-person sessions.
Increased knowledge of standard referral protocols for patients with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) to be discharged back into the community.	Up to 5 behavioral health providers are more aware of the available tools to refer attributed IDN patients participating in the Critical Time Intervention (CTI) strategy by June 30, 2018.	Achieved: All CTI staff have been trained by [redacted] in the CTI Staff training between the November 2017 and March 2018 trainings.	Achieved in prior reporting period, with CTI staff on-boarded since the training having attended all CoP sessions and received training as outlined by [redacted]
Increase in the capacity of the IDN providers to support the transitions of the target sub-population from hospital settings to the community.	Up to 4 care coordinators/case managers are trained in the use of the available HIT platforms (ENS, DSM, SCP and data aggregation) to support information sharing and communication by June 30, 2018.	Not achieved: [redacted] (ENS/SCP) and [redacted] (DSM) contracting was completed at the end of the reporting period. Staff will be trained by the vendor by April 2019.	Achieved, with all CTI staff being trained in the use of currently available platforms, which include DSM and ENS/SCP.
Increased skills in the use of community-based services available to address daily living needs.	All patients engaged in CTI will report an increase in utilization of needed community-based services such as housing assistance, legal assistance, family and support services and employment assistance, if applicable to their individual needs, as a result of participating in CTI.	Achieved: All clients engaged in CTI are referred to community-based services and supported through engagement with referral sources as needed. Referrals are tracked by case managers, with challenges including the availability of community resources and the limited ability to adequately track and report this data. GNMH will work with the IDN to identify strategies in next reporting period.	Achieved, with all clients engaged in CTI being referred to community-based services and supported through engagement with referral sources as needed. Referrals are tracked by case managers, however challenges include the availability of community resources. Manual tracking of community-based services collaboration and referral has improved.

C-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)					
	Projected Total Need to Achieve IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Clinical Supervisor: Licensed Therapist	.15	0	0	0	.15	.15
Team Coordinator: Licensed Therapist and/or Case Manager	1.0	0	1	1	1	1
Case Manager	2.5	0	1	2	2	2

C-4. IDN Community Project: Budget

Critical Time Intervention (CTI) strategies and subsequent funding allocations mostly entail staffing expenses, including salary/wages and benefits, travel reimbursement, computers, and cell phones. Additionally, funding was allocated to support office supplies and client-related emergency expenses, as well as indirect costs, capped at 21% (as approved by the IDN Executive Committee). They also include funding to support interpretation services.

Total proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $788,231.90

- CY 17 (July 2017 – December 2017): $61,798.70
- CY 18 (January 2018 – December 2018): $242,144.40
- CY 19 (January 2019 – December 2019): $242,144.40
- CY 20 (January 2020 – December 2020): 242,144.40

Total funding expended (July 2017 – June 2019): $219,121.00

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $78,580.18
- CY 19 (January 2019 – June 2019): $140,541

Projections are displayed CY 2019, CY 2020 and CY 2021 (January to June) in the IDN Community Project Budget Table (C-4a) at the end of this section. Below is more detail to support those budgets.

Approved funding allocations/projections

Employee salary/wages to support:

- Clinical Supervisor: .15 FTE (Licensed Therapist)
- Team Lead/Coordinator: 1 FTE (Case Manager)
- Specialist: 2 FTE (Case Manager)

Consultants:

- Interpretation services

Equipment to support staff under Salary/Wages:

- Laptops and desktops

Supplies to support staff under Salary/Wages and client needs:

- Office

- Medical/lab/pharmacy

Travel to support staff under Salary/Wages:
- mileage

Current expenses to support staff under Salary/Wages:
- mobile phones

Other:
- Indirect costs: capped at 21% per IDN 3 Finance Governance Committee
- Client services: rental assistance, medication assistance, grocery store gift cards, etc.

Funding expenditures during reporting period

The IDN implements a reimbursement only model for all funding allocations following the state fiscal year (SFY) sub-contract time frame (July – June). For the expenditures reflected in the narrative and budget table below, some of the services were provided during the previous reporting period (July – December 2018) and some invoices have been received, but not fully processed and reflected in the outlined for the current reporting period.

Expenditures reflected in the budget table below reflect the following:

Employee salary/wages to support:
- Clinical Supervisor: .15 FTE (Licensed Therapist)
- Team Lead/Coordinator: 1 FTE
- Specialist: 2.5 FTE (Case Manager)

Consultants:
- Interpreter services through Language Line Solutions

Equipment to support staff under Salary/Wages:
- Laptop for CTI Specialist

Travel:
- Mileage for CTI Coordinator/Team Lead (1 FTE) and CTI Specialists (2 FTEs)

Current expenses to support staff under Salary/Wages:
- Telephones for CTI Coordinator/Team Lead (1 FTE) and CTI Specialists (2 FTEs)

Other (Indirect costs):
- Capped at 21% per IDN 3 Finance Governance Committee
- Client services, including:
  - rental assistance
  - groceries
  - medications
  - driver's licenses

C.4a: IDN Community Project Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan - June 2019 Actuals	July - Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	$591,796	$0	$0	$58,628	$103,490	$107,420	$214,839	$107,420	$591,796
Employee Benefits	$0	$0	$0	$0	$0	$0	$0	$0	$0
Consultants	$3,891	$0	$0	$0	$3,891	$0	$0	$0	$3,891
Equipment	$30,200	$0	$0	$0	$931	$7,317	$14,635	$7,317	$30,200
Supplies (sum of lines below)	$4,100	$0	$0	$3,776	$324	$0	$0	$0	$4,100
Educational	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Lab/Pharmacy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Office	$3,776	$0	$0	$0	$324	$0	$0	$0	$324
Travel (mileage/parking expenses)	$19,093	$0	$0	$1,611	$6,143	$2,835	$5,670	$2,835	$19,093
Occupancy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Current Expenses (sum of lines below)	$2,203	$0	$0	$929	$1,274	$0	$0	$0	$2,203
Telephone	$2,083	$0	$0	$809	$1,274	$0	$0	$0	$2,083
Internet costs	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postage	$0	$0	$0	$0	$0	$0	$0	$0	$0
Printing and Copying	$120	$0	$0	$120	$0	$0	$0	$0	$120
Audit and Legal	$0	$0	$0	$0	$0	$0	$0	$0	$0
Insurance	$0	$0	$0	$0	$0	$0	$0	$0	$0
Board Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Software	$0	$0	$0	$0	$0	$0	$0	$0	$0
Marketing/Communications	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Education and Training	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subcontracts/Agreements	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other (specific details mandatory):	$0	$0	$0	$0	$0	$0	$0	$0	$0
Recruitment Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0
Sign-on Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Referral Bonuses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Relocation Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Student Loan Repayment/Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employee Recognition/Retention Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
CMEs/Professional Development	$0	$0	$0	$0	$0	$0	$0	$0	$0
Professional Development Fees/Dues	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Licensing/Certification Supervision Stipend	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other: please specify below	$137,129	$0	$0	$13,637	$24,488	$24,751	$49,502	$24,751	$137,129
TOTAL	**$788,412**	**$0**	**$0**	**$78,580**	**$140,541**	**$142,323**	**$284,645**	**$142,323**	**$788,412**

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

Organization/Provider	Agreement Executed (Y/N)
Greater Nashua Mental Health Center (GNMHC)	Y

C-6. IDN Community Project: Standard Assessment Tools

Standard Assessment Tool Name	Brief Description
CTI Brief Assessment	This tool is utilized upon referral with the client to assess the following: A. the individual's presenting problem; B. the individual's needs and strengths; C. a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission; D. a pertinent social, family, and medical history; and E. evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the individual's needs.

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

Protocol Name	Brief Description	Use (Current/Under development)
Screening/Assessment	SNHMC ACCESS Behavioral Health Initial Assessment Protocols - SNHMC Emergency Department/Acute Community Crisis Evaluation Service System (ACCESS): the ACCESS Team Counselor conducts a psychosocial evaluation with the patient/client, following the Behavioral Health Initial Assessment Protocols. This includes completing the ACCESS Assessment Evaluation Form and Suicide Assessment Checklist-R2.	Current
Screening/Assessment	CTI Pre-Referral Form Upon determination of disposition and appropriateness for patient/client need for CTI program, the ACCESS Team Counselor completes the CTI Referral Form with the patient/client. This form provides an overview of the model, including the phases over 9 months, as well as the eligibility criteria and information needed for inclusion with the referral.	Current
Screening/Assessment	NH Hospital: as patient/client approaches discharge from facility, the NH Hospital Care/Discharge Coordinator completes the CTI Referral Form to determine eligibility for the program, which preferably, could include pre- CTI services while the patient/client is preparing for discharge.	Current
Screening/Assessment	SNHMC Behavioral Health Unit (inpatient or partial hospitalization program): as the patient/client approaches discharge from program, the Director or Clinical Manager completes the CTI Referral Form to determine eligibility for the program, which preferably, could include pre-CTI services while the patient/client is preparing for discharge.	Current

Screening/Assessment	Designated Receiving Facility (DRF): as the patient/client approaches discharge from program, the Director or Clinical Manager completes the CTI Referral Form to determine eligibility for the program, which preferably, could include pre-CTI services while the patient/client is preparing for discharge.	Current
Screening/Assessment	Closed Loop Referral - The CTI Referral Form then sent via direct secure message/fax (via [redacted] or Integrated direct secure messaging platform within EHR) to GNMHC, with referring provider organization utilizing IDN recommended guidelines/protocols for closed loop referral.	Current
Screening/Assessment	CTI Case Management Assessment Tool - Upon receipt of CTI Referral Form, the CTI specialist (Case Manager) completes the CTI Case Management Assessment Tool with the patient/client to determine their case management needs, including eligibility for the CTI program.	Current
Screening/Assessment	CTI Documentation Checklist - If determined appropriate for CTI, a CTI Specialist (Case Manager) will be assigned and will initiate completion of any remaining intake forms, including patient consent and release of information, using the CTI Documentation Checklist.	Current
Screening/Assessment	Closed loop referral - If deemed inappropriate/not eligible for CTI, the CTI (Coordinator/Specialists) will complete the closed loop referral protocol by either 1) following up with the case manager/care coordinator assigned to the patient/client who is providing mental health, medical and social service support coordination for the patient/client, or 2) refer the patient/client to another appropriate treatment provider within GNMHC or the IDN, using IDN recommended guidelines/protocols for closed loop referrals.	Current
Treatment	CTI Phase Plan - Patient/client is provided with intensive case management with a CTI Specialist. If possible, all patients/clients will engage in the Pre-CTI Phase, which provides for up to 10 hours of building rapport and trust in case management planning and services. The 3 CTI phases occur over 9 months between the patient/client and their CTI Specialist, as well as the primary care provider and a mental health treatment provider. The CTI Phase Plan Form identifies the 3 focus areas with goals mutually agreed upon with the patient/client, including psychiatric treatment/medication management; substance use treatment; daily living skills training; housing crisis prevention and management; money management; and family interventions. There is a starting date and a closing date for the end of each phase	Current
Treatment	Crisis Plan - The CTI Specialist develops a Crisis Plan with the patient/client to ensure the patient/client knows their resources and supports to avoid the use of the emergency department or other services to that will not provide the appropriate supports.	Current
Treatment	Release of Information Form - The CTI Specialist makes connections for the patient/client with their primary care provider and appropriate behavioral health provider(s), ensuring they follow-through in attending appointments and completing applicable consent and release of information (ROI) forms for information sharing among their providers and care coordinators/case managers.	Current
Treatment	Patient Consent - As appropriate and deemed necessary, patient consent will be solicited to share information with the care team.	Current

Management	CTI Progress Notes - The CTI Specialist completes CTI Progress Notes as part of the phase plan implementation, including documenting ongoing interactions with the patient/client, their providers and social service support organization resources.	Current
Management	CTI Supervision Form - The CTI Coordinator utilizes the CTI Supervision Form to conduct weekly case meetings with the CTI Specialists that focus on high priority patients/clients based on past week's fieldwork and any change to client status and records explanation and one reason code, such as a big change in the patient/client's life, or non-compliance with their phase plan.	Current
Management	CTI Phase Date form - The CTI Coordinator utilizes the CTI Phase Date form to track patients/clients and the phases they are in to monitor appropriate caseload fidelity. The Coordinator also utilizes a spreadsheet to monitor and track client progress and disposition.	Current
Referral	Referral Form - Throughout Phase II of the CTI model, the CTI Specialist works with patient to make active referrals to a primary care physician (if patient lacks one) and mental health counseling while implementing a transition plan. Emotional support is consistently provided in moving the patient toward more self-sufficiency.	Current
Referral	CTI Closing Note - Upon determination the patient has completed the 3 CTI phases, the CTI Closing Note is completed.	Current

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

Project Team Member	Roles and Responsibilities
Clinical Supervisor	Monitors fidelity of the program; provides clinical supervision and consultation regarding diagnosis, disposition, engagement strategies and any other areas of training needed; facilitates weekly case conference meetings with CTI Team and IDN partner meetings; oversees referrals and discharges to program
CTI Team Lead (Coordinator)	Provides in the field monitoring and support of CTI Specialists; Coordinates field assignments and schedules/covers for Clinical Supervisor duties such as referrals and meetings in the absence of the supervisor
CTI Specialist (Case Manager)	Provides screening and assessment of patient; works with patient to create goals and plan for transition, including securing a primary care physician, mental health clinician and community-based supports for those needs that address their social determinants of health; maintains relationships with patient's providers and caregivers, providing transportation and ensuring follow-up when needed

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

See attachment_C.9a: Critical Time Intervention (CTI) Training Plan

Project Scoring: IDN Community Project Process Milestones

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

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

Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

See attachment_D.1a: IDN Community Project: Implementation Plan

Implementation Plan Key Milestones

IDN 3's Community Project Implementation Plan for Expansion in Substance Use Disorder Treatment focuses on these key areas:

- Development/Implementation of Protocols (standardized patient assessment tools, treatment, management, referrals)
- Development/Implementation/Training of Team Member Workforce
- Development/Implementation of Agreements with Collaborating Organizations

With continued challenges regarding engagement of the Partnership for Successful Living, the D3 active programs remained static to prior reporting periods with minimal addition or expansion of SUD-related treatment options and with continued focus on:

- Expanded SUD treatment for youth/adolescents
  - screening and referrals from Project IMPACT in Nashua Middle School to further assessment and individual SUD treatment (The Youth Council)
- Community-based non-treatment groups:
  - spirituality non-treatment groups with screening and referrals/connections to higher levels of treatment (The Emmaus Institute)
- Screening and care transitions from hospital emergency departments:
  - assessment and referral to outpatient treatment and other supportive services (Southern NH Medical Center)

Development/Implementation of Protocols (standardized patient assessment tools, treatment, management, referrals)

Progress

Through this reporting period *The Youth Council's (TYC)* two A1-funded Project IMPACT counselors (2 FTEs Behavioral Health Clinicians) supported 77 unique youth in 2 of the 3 Nashua middle schools. The counselors completed 20 screenings for substance use utilizing the CRAFFT assessment tool with no positive screens resulting from the assessment. They also utilized the PHQ-9 assessment for 11 youth with an outcome of 6 screening positive for depression. Four of those screening positive were referred to TYC and began engaging in treatment with an additional 2 youth being referred to other IDN region therapeutic services. Additionally, the Project IMPACT counselors initiated a new group of 8th grade boys in further developing and utilizing social skills at one of the Nashua middle schools. Counselors observed progress in learning to work together to achieve common goals and expressions of kindness towards one another resulting in an increase in positive social skill interactions.

During the reporting period TYC therapist (1FTE MLADC) expanded her SUD individual treatment office visits to 140 varying from assessments to treatment visits. All youth were screened for depression and SUD with all 11 Medicaid beneficiaries completing the CCSA in that reporting period. These 11 CCSAs resulted in 10 positive depression screenings and 6 positive substance use risks (1 SUD only, 5 depression & SUD).). All 11 youth had follow up plans developed on the day of screening. This population was additionally screened for depression and SUD each time they came in for treatment.

TYC continued their working relationship with the master's level Mental Health Counseling intern from Rivier University who graduated in May with his Master's degree. The intern continued to work closely with the MLADC and LCMHC and interacted with youth referred for counseling by Project IMPACT supporting the intake process and supervised counseling. The team also continued to ensure success in parental consent achievement leveraging the opportunity to educate parents and youth regarding the support services provided (screening/assessments and counseling) as well as reinforcing additional resources within the school environment.

The Emmaus Institute Licensed Pastoral Psychotherapist (.03 FTEs Licensed Therapist) supported individuals by providing clinical expertise for those who chose to consider the benefits of spirituality/faith based support via continuation of previously established weekly spirituality groups. Although weekly attendance varied the total participation levels increased from 18 last reporting period to 56 this reporting period. These participants included both repeat participants and first-timers and included individuals in varying stages of recovery from substance misuse and mental health disorders, challenging housing situations and in varying level of isolation. The sessions held at the peer support agency Revive attracted 38 unique individuals while the sessions held at the United Methodist Church attracted 18 unique individuals. Discussions are underway to broaden the Spirituality Groups to include facilitation by Swahili pastors for a congregation of Swahili speaking congregants.

Additionally, The Emmaus Institute conducted a Lunch & Learn presentation on *Spirituality in Patient Care* attended by 35 clinicians and support staff from Lamprey Health. The intent of these trainings is to increase knowledge and responsiveness of healthcare providers/support staff to the spirituality needs of patients as part of an integrated care setting. According to Emmaus, "Research has demonstrated that religious beliefs and activities are often valuable resources that help patients cope with difficult situations and may be utilized by mental health specialists to help speed recovery from emotional illness or maintain remission."

The SUD Transitional Care Coordinator (.5 FTEs Care Coordinator) with *Southern NH Medical Center* (SNHMC) leveraged their Patient and Family Services Recovery Care Assessment tool with 158 total patients visiting the ED of which 48 were Medicaid patients (Medicaid data only from March-June). Of this population, 16 declined services, 3 were detox admissions, 13 leveraged intensive outpatient services, 6 referred to med management support, 9 went into 28-day inpatient admissions, 4 were referred to Granite Pathways and 2 were sober living admissions.

Barriers/Challenges and Mitigation Plans:

The SNHMC Recovery Care Coordinator role is an IDN-3 funded .5FTE with funding for the remaining .5FTE from another source. With only 1FTE supporting individuals in the ED as well as transitioning out from inpatient services at Southern NH Medical Center, there is a gap in support for the house she is not working (nights & weekends). Although other roles attempt to fill the lack of the Recovery Care Coordinator, this leaves individuals without the full offering of support which could help in their transition. This barrier is mitigated through the ED case managers texting the Recovery Care Coordinator while off duty enlisting support to identify resources but is not an ideal nor sustainable solution.

Development/Implementation of Agreements with Collaborating Organizations

In further development of partnerships, the IDN-3 Admin team facilitated several discussions between the SNHMC SUD Recovery Care Coordinator (RCC) and *Greater Nashua Mental Health's* CTI leadership team. The catalyst to these discussions was the feedback during monthly IDN-3 partner liaison meetings with the RCC regarding the barriers and challenges she experiences in best serving the population she supports. Due to lack of access to key patient-related data points (i.e. whether they are already under the care of a BH provider, the name of the assigned case manager, date last seen, etc.) the RCC is left to depend on the patient in crisis to develop an action plan for transition during a time the individual's recollection and engagement may not be at their peak. This information is critical in the discharge/continuum of care in order to avoid gaps in care. Sharing and storing patient information amongst providers using this approach organically leads to shared care planning within [redacted] and surfaces provider concerns with patient consent and the sharing of confidential patient information. These discussions are continuing with the IDN-3 Admin team providing guidance through the process development.

The SNHMC SUD Recovery Care Coordinator (RCC) strengthened the relationships with IDN member entities, including Granite Pathways and peer support agencies. The RCC continued to work with *Revive Recovery Center* and attended monthly Safe Station meetings as well as bi-monthly Continuum of Practice meeting which focus on MAT in the ED. The RCC collaborated with the director of SUD services at Elliot Hospital, to coordinate SUD services under the new Solution Health System (a partnership between Elliot Hospital and SNHMC).

With the support of the IDN-3 Admin team, connections were made between *The Youth Council* and *Dartmouth Hitchcock* with the goal of educating primary care physicians as to the services of Project Impact in the school environment as well as supporting care coordination with IDN primary care providers, including referrals for well-care visits.

Development/Implementation/Training of Team Member Workforce

Progress

The Youth Council has been successful in retaining their IDN-funded staff with little to no turnover throughout the lifecycle of the demonstration. The retention of their 2 master's level counselors, their master's level intern as well as their MLADC have supported seamless continuation of their programs and generated ideas for future growth (pending additional funding) outside of Nashua and into more outlying communities. There are several factors supporting this retention inclusive of student loan repayment and professional development monies funded by IDN-3. This professional development for the IDN-3 funded staff included training on topics such as Motivational Interviewing, Chronic Diseases, Adolescent BIRT, Stigma Across Cultures and Mindfulness in Youth which all directly support the interactions with the clientele they serve.

Barriers and Mitigation Plans to Future Achievement

As was reported last reporting period, lack of progress in implementing the remainder of this initiative's implementation plan is due to continued delays in engaging key partners in subcontract completion as well as a recent request for modification to the initial implementation plan by the Partnership for Successful Living (Keystone Hall & Harbor Homes), as well as St. Joseph Hospital and Physician Practices.

In addition, Greater Nashua Mental Health recently provided a documented request to withdraw from

the D3 project as it relates to the development and facilitation of a Substance Use Disorder Group at a local shelter. The reason behind this was that the leadership had changed in the location where they had planned to conduct the weekly sessions.

Pre-treatment community-based groups (.03 FTEs Licensed Therapist and .03 FTEs Peer Support Specialist):

- Issue: Greater Nashua Mental Health recently provided a documented request to withdraw from the development and facilitation of a Substance Use Disorder Group at a local shelter due to change in leadership at the shelter with whom the original discussions were held with combined with staffing challenges within their own Substance Use Disorder department within the mental health agency.
- Mitigation plan: The IDN has determined it will not pursue completion of this strategy; instead, it will work with the Clinical Governance Committee to utilize those funds for other project strategies.

Screening and care transitions from hospital emergency departments:

- Issue: St. Joseph Hospital and Physician Practices merger with Covenant Health has impacted the timeliness of prioritizing and executing the IDN subcontract. This caused delays in moving forward with implementation of SUD Transitional Care Coordinator in their Emergency Department (.5 FTEs Care Coordinator).
- Mitigation plan: the IDN will continue to work with leadership at St. Joseph throughout the remainder of 2019 to support implementation of this strategy, including collaborating with Southern NH Medical Center and their lessons learned from their implementation of this role.

Expanded community-based care coordination for SUD referrals to treatment:

- Issue: Harbor Homes and Keystone Hall had not executed the IDN sub-contract

- Mitigation: the IDN has had very recent discussions with the organizations and anticipates execution of the subcontract by mid-August 2019

D-2. IDN Community Project: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Increased knowledge of universal screening/ assessment process (Comprehensive Core Standardized Assessment), across 10 domains to guide the treatment and management of the target sub- population.	Up to 9 IDN- funded positions in the D3 strategies participate in universal screening training by 12/31/18.	Achieved in prior reporting period (6/30/18) and additional CCSA training this reporting period	Achieved, with no further progress made
Increased knowledge of patient consent requirements, especially related to 42 CFR Part 2 to guide the treatment and management of the target subpopulation.	Up to 9 IDN- funded positions in the D3 strategies participate in universal screening training by 12/31/18.	Not Achieved: although 42 CFR Part 2 training had been held in a prior reporting period, there were not 9 IDN D3- funded positions in participation	Not Achieved, with no additional 42 CFR Part 2 training participation being reported.
Increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub- population.	Up to 9 IDN- funded positions in the D3 strategies participate in training on communication protocols and workflows (through HIT vendor technologies) by 12/31/18.	Not Achieved: as of yet, no D3 IDN-funded positions attended	Achieved through IDN sharing of its Guidelines/Protocols with its membership, as well as training being provided by [redacted] (direct secure messaging) and [redacted] (event notification/shared care plan) during the reporting period.
Increased knowledge of American Society of Addiction Medicine (ASAM) guidelines to ensure proper placement, continued stay and transfer/discharg e of patients with addiction and co- occurring conditions.	Up to 4 of the IDN- funded positions in the D3 strategies participate in the ASAM training by 12/31/18.	Not Achieved: no ASAM trainings were held	Not Achieved, with no IDN D3- funded positions having participated in this training during the reporting period.
Increased knowledge of the goals of Screening, Brief Intervention and Referral to Treatment (SBIRT) and other treatment and support resources available for referring youth who positively screen for substance use to guide the treatment and management of the target subpopulation.	Up to 10 Primary Care Physicians (PCPs) across the IDN Member provider practices have met with the IDN funded Student Assistance Program Counselors to receive information about SBIRT and referral resources by 12/31/18.	Achieved in prior reporting periods 12/31/17 & 6/30/18 additional meetings in this reporting period did not take place	Achieved in prior reporting period with no further progress made

Increased knowledge of the goals of Screening, Brief Intervention and Referral to Treatment (SBIRT) and other treatment and support resources available for referring youth who positively screen for substance use to guide the treatment and management of the target subpopulation.	New relationships with up to 5 primary care physician practices through up to 10 presentations to providers to educate them about the services available from Project IMPACT by December 31, 2018	Achieved in prior reporting periods 12/31/17 & 6/30/18 with engagement with Foundation Medical Partner practices, Harbor Homes, Lamprey Health, Main Street Pediatrics & Adolescent Medicine	Achieved in prior reporting period with no further progress made
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub- population.	Brief intervention and/or education and assessment services for up to 60 students by the end of the first sub-contracting period (June 30, 2018).	Achieved in prior reporting periods 12/31/17 & 6/30/18 with services to 68 students and additional students this reporting period: 6 middle school youth were referred to Project IMPACT counselors, and screened with CRAFFT tool. No positive screening for depression or substance use. Two completed CCSAs done with children referred from the community/drug court.	Achieved in prior reporting period with a total of 71 students serviced; 7 referred this reporting period; no positive SUD, 6 positive depression screenings; additionally, 15 youth were seen for treatment (11 of those had Medicaid and all 11 were given the CCSA; all youth were screened for depression and SUD)
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub- population.	Referrals to higher levels of services or other supports for students not appropriate for brief intervention/education based upon completion of the S2BI tool.	Achieved: - 10 children/youth referred to BH services provided by licensed therapist as follows: 2 referred by school counselors had no shows 8 referrals received from the drug court/ community outreach	Achieved in prior reporting period with an additional 15 youth referred to BH services provided by licensed therapist: 4 from Project Impact Counselors and 11 from community outreach
Increased connections with care team members, including primary care physicians to monitor and manage the patient's goals and treatment plan.	Referrals for well- child visits to PCPs for up to 10 students who had not previously completed a well- child (physical) visit in the last 12 months, using appropriate consent procedures by the end of the first sub-contracting period (June 30, 2018).	Achieved in prior reporting periods 12/31/17 & 6/30/18 with 7 referrals; no additional referrals this reporting period	Achieved in prior reporting period with 4 additional well child referrals; 4 additional PCP referrals for suicidal ideation, nutrition, weight management and med check; all current therapy clients, except 1 youth, have attended a well-child visit
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub-population.	Treatment provided through medical detox/Medication Assisted Treatment (MAT) to up to 125 patients by the end of the end of the sub-contracting period (June 30, 2018).	Achieved: - 62 patients referred to appropriate SUD services upon discharge from the ED as follows: - 12 patients referred for detox services from the ED; 10 Patients referred to MAT services from the ED; - 34 Patients referred to outpatients services with SUD recovery homes/ partial hospitalizations upon discharge from ED; 6 Patients were referred	Achieved in prior reporting period with no further progress reported

		back to Safe Stations upon discharge from the ED.	
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub-population.	Up to 80 individuals will participate in the community-based pre-treatment groups and/or the spirituality non-treatment groups by the end of the first sub-contracting period (June 30, 2018).	Achieved: - 18 individuals attended the community spirituality non-treatment groups - 14 Bio-psychosocial assessments completed by Emmaus Institute with licensed pastoral psychotherapist (4 completed CCSAs screenings reported) GNMHC/HEARTS non-treatment groups to be held in the future	Achieved: Achieved in prior reporting period with the following additional progress: 56 unique attendees for community spirituality non-treatment groups at 2 locations
Increased access to behavioral health care and community-based social services and supports across the IDN to guide the treatment and management of the target sub- population.	Up to 125 patients seen in the Emergency Departments at SNHMC and St. Joseph Hospital will participate in screening/assessment and discharge/referral to IDN Member Entity SUD treatment providers by the end of the sub-contracting period (June 30, 2018)	Achieved - 127 patients seen in the ED at SNHMC & assessed with the Patient and Family Services Recovery Care Assessment tool. - 62 patients referred to appropriate SUD services upon discharge from the ED as follows: - 12 patients referred for detox services from the ED - 10 Patients referred to MAT services from the ED. - 34 Patients referred to outpatients services with SUD recovery homes/ partial hospitalizations upon discharge from ED. - 6 Patients were referred back to Safe Stations upon discharge from the ED.	Achieved in prior reporting period with the following progress in the ED at SNHMC: 158 total patients seen 48 Medicaid patients (March-June) 16 of those declined services 3 detox admissions 13 intensive outpatient services 6 med management 9 into 28-day inpatient admissions 4 Granite Pathways referrals 2 sober living admissions

D-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)					
	Projected Total Need to Achieve IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Registered Nurse	1.2	0	0	0	0	0
Licensed Therapist	.06	0	0	.03	.03	.03
Master Licensed Alcohol and Drug Use Counselor (MLADC)	14	0	0	0	2	4
Behavioral Health Clinician/Specialist	1	0	1	0	0	0
Care Coordinator	1	0	0	0	.5	.5
Peer Support Specialist	.03	0	0	0	0	0

Barriers/Challenges and Mitigation Plans:

Registered Nurse

Barriers/Challenges: The Partnership for Successful Living (Harbor Homes and Keystone Hall), who indicated they would on-board a detox nurse (.6 FTEs) and non-detox nurse (.6 FTEs) has not yet executed the IDN sub-contract to date.

Mitigation Strategies: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets. During the reporting period, the IDN Governance Committees approved the changes in scope and budget. Revised project plans (which have been submitted to DHHS for review) reflect changes in the targets, with PSL noting that MLADCs are not billable under FQHCs, and therefore requesting to use supervision stipends to support staff moving to an LICSW or LCMHC.

Licensed Therapist

GNMH Community-Based Groups Facilitator: In March 2019, GNMH notified the IDN that they would not be moving forward with implementing these weekly groups, so this strategy (and its designated staffing at .03 FTEs) will not move forward.

Registered Nurse

Barriers/Challenges: The Partnership for Successful Living (Harbor Homes and Keystone Hall), who indicated they would on-board a detox nurse (.6 FTEs) and non-detox nurse (.6 FTEs) has not yet executed the IDN sub-contract to date.

Mitigation Strategies: The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets. During the reporting period, the IDN Governance Committees approved the changes in scope and budget. Revised project plans (which have been submitted to DHHS for review) reflect changes in the targets, with PSL noting that MLADCs are not

billable under FQHCs, and therefore requesting to use supervision stipends to support staff moving to an LICSW or LCMHC.

MLADCs

Barriers/Challenges:

- The Partnership for Successful Living (Harbor Homes and Keystone Hall), who indicated they would target up to 8 Master's Level clinicians who would benefit from IDN stipends to offset the supervision time of staff. They were not able to make progress in this target, due to not executing IDN sub-contracts with funds to support these strategies during the reporting period.
- Greater Nashua Mental Health, who indicated they would target up to 4 Master's Level staff achieving certification.
- Southern NH Medical Center, who has 1 Master's Level staff person targeted to achieve MLADC certification.
- LaMora Psychological Associates has struggled with meeting the NH State Statutes for data sharing related to this role (.03 FTEs) and has been working with the NH State Board, as well as their legal counsel to identify next steps to allow them to engage.

Mitigation Strategies:

- The IDN has been working closely with the Partnership in revising their originally-approved strategies and budgets. During the reporting period, the IDN Governance Committees approved the changes in scope and budget. Revised project plans (which have been submitted to DHHS for review) reflect changes in the targets, with PSL noting that MLADCs are not billable under FQHCs, and therefore requesting to use supervision stipends to support staff moving to an LICSW or LCMHC.
- GNMH has made significant progress in meeting their goals, with 3 out of the 4 staff members achieving MLADC certification. GNMH has utilized IDN funding to support supervision stipends and will continue to receive these incentive funds into the next reporting period to support the remaining 1 staff member targeted to achieve MLADC certification.
- SNHMC's SUD Acute/Transitional Care Coordinator is still working on her certification, but not having achieved it to date. However, the IDN has provided additional funds to support her attendance at the New England School of Addiction and Prevention Studies in July.
- LaMora provided a formal letter in June 2019 requesting to be removed from IDN-3 due to its ethical challenges for sharing behavioral health data. This letter has been provided to DHHS to determine how this development affects the region's Medicaid attributed lives.

Behavioral Health Clinician/Specialist

Barriers/Challenges:

- The Youth Council received IDN funding to support 3 positions to support their Project IMPACT program in the Nashua Middle Schools. To date 2 of those individuals have been retained, with one leaving their role in early 2018.

Mitigation Strategies:

- The Youth Council Project IMPACT vacancy was filled through their D3 project goal of expanding access to SUD treatment for adolescents/young adults, so this role is now represented under the MLADC provider role category.

Care Coordinator (Bachelor's and Master's Level)

Barriers/Challenges: The remaining .5 FTEs Care Coordinator is associated with St. Joseph Hospital, as this role was approved as an emergency department SUD Acute/Transitional Care Coordinator. However, SJH has not executed their IDN sub-contract and scope of work for this D3 project funding allocation to date.

Mitigation Strategies: The IDN continues to work with SJH to identify how to best move forward in their D3-related strategies, which include this .5 FTE care coordinator in the emergency department, similar to what has been operationalized with SNHMC. With the ongoing challenges associated with the merger with Covenant Health and migration to a new EHR, SJH has shared that leadership is still trying to identify what makes the most sense for their organization moving forward to achieve the IDN deliverables.

Peer Support Specialist

Barriers/Challenges: GNMH weekly pre-treatment community-based groups: In March 2019, GNMH notified the IDN that they would not be moving forward with implementing these weekly groups, so this strategy (and its designated staffing) will not move forward.

D-4. IDN Community Project: Budget

Funding associated with this project include support staffing-related expenses, including salary/wages and benefits, travel reimbursement, computers and cell phones, as well office supplies and indirect costs, capped at 15% (as approved by the IDN Executive Committee).

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $784,003.00

- CY 17 (July 2017 – December 2017): $84,367.00
- CY 18 (January 2018 - December 2018): $233,212.00
- CY 19 (January 2019 – December 2019): $233,212.00
- CY 20 (January 2020 – December 2020): $233,212.00

Total funding expended (July 2017 – June 2019): $149,827.87

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $80,257.87
- CY 19 (January 2019 – June 2019): $69,570.00

Projections are displayed for the July to December 2019, as well as CY 2020 and CY 2021 (January to June) in the IDN HIT Budget Table (B1-5a) at the end of this section. Below is more detail to support those budgets.

Approved funding allocations/projections

Employee salary/wages to support:

- Licensed Pastoral Psychotherapist: .25 FTEs
- Mental Health Counselor (MLADC): .15 FTEs
- Peer Support Specialist Facilitator: .20 FTEs
- Nurse Case Manager: 1.2 FTEs
- SUD Transitional Care Coordinator: 1 FTE
- Master's Level Student Assistance Counselor: 1 FTE

Employee Benefits to support:

- employee salary/wages for staffing identified above

Supplies to support:

- office and educational supplies to support project strategies

Travel to support:

- mileage
- parking

Current expenses to support:

- audit and legal
- mobile phones

Software:

- case management software

Indirect costs:

- capped at 15% per IDN 3 Finance Committee

Funding Expenditures

The IDN implements a reimbursement only model for all funding allocations following the state fiscal year (SFY) sub-contract time frame (July – June). For the expenditures reflected in the narrative and budget table below, some of the services were provided during the previous reporting period (July – December 2018) and some invoices have been received, but not fully processed and reflected in the outlined for the current reporting period.

Employee salary/wages and benefits:

- The Emmaus Institute: Licensed Pastoral Psychotherapist (.25 FTEs)
- Southern NH Medical Center: SUD Transitional Care Coordinator: (.5 FTE)
- The Youth Council: MLADC (.5 FTEs)

Travel to support:

- The Youth Council: mileage and parking

Software:

- case management software

Other:

- The Youth Council: student loan repayment
- The Youth Council: indirect costs (capped at 15% per IDN Finance Committee)

D-4a: IDN Community Project Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan - June 2019 Actuals	July - Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	$739,350	$0	$0	$72,075	$24,000	$160,819	$321,638	$160,819	$739,350
Employee Benefits	$938	$0	$0	$938	$0	$0	$0	$0	$938
Consultants	$0	$0	$0	$0	$0	$0	$0	$0	$0
Equipment (sum of lines below)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Rental	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repair and Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0
Purchase/Depreciation	$0	$0	$0	$0	$0	$0	$0	$0	$0
Supplies (sum of lines below)	$3,933	$0	$0	$3,933	$0	$0	$0	$0	$3,933
Educational	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Lab/Pharmacy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Office	$0	$0	$0	$3,933	$0	$0	$0	$0	$3,933
Travel (mileage/parking expenses)	$1,189	$0	$0	$491	$698	$0	$0	$0	$1,189
Occupancy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Current Expenses (sum of lines below)	$800	$0	$0	$800	$0	$0	$0	$0	$800
Telephone	$0	$0	$0	$0	$0	$0	$0	$0	$0
Internet costs	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postage	$0	$0	$0	$0	$0	$0	$0	$0	$0
Printing and Copying	$0	$0	$0	$0	$0	$0	$0	$0	$0
Audit and Legal	$800	$0	$0	$0	$0	$0	$0	$0	$0
Insurance	$0	$0	$0	$0	$0	$0	$0	$0	$0
Board Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Software	$350	$0	$0	$280	$70	$0	$0	$0	$350
Marketing/Communications	$0	$0	$0	$0		$0	$0	$0	$0
Staff Education and Training	$225	$0	$0	$225		$0	$0	$0	$225
Subcontracts/Agreements	$32,948	$0	$0	$0	$32,948	$0	$0	$0	$32,948
Other (specific details mandatory):	$5,000	$0	$0	$0	$5,000	$0	$0	$0	$5,000
Recruitment Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0
Sign-on Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Referral Bonuses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Relocation Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Student Loan Repayment/Reimbursement	$5,000	$0	$0	$0	$5,000	$0	$0	$0	$5,000
Employee Recognition/Retention Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
CMEs/Professional Development	$0	$0	$0	$0	$0	$0	$0	$0	$0
Professional Development Fees/Dues	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Licensing/Certification Supervision Stipend	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other: please specify below	$8,370	$0	$0	$1,516	$6,854	$0	$0	$0	$8,370
TOTAL	**$793,103**	**$0**	**$0**	**$80,258**	**$69,570**	**$160,819**	**$321,637**	**$160,819**	**$793,103**

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

Organization/Provider	Agreement Executed (Y/N)
The Youth Council	Y
Harbor Homes	N
Keystone Hall	N
The Emmaus Institute	Y
Greater Nashua Mental Health Center	Y
St. Joseph Hospital	N
Southern NH Medical Center	Y

D-6. IDN Community Project: Standard Assessment Tools

Standard Assessment Tool Name	Brief Description
Screening to Brief Intervention (S2BI)	CRAFFT tool was introduced November 2018 and replaces S2BI
IDN3 CCSA Adult CCSA Paper Version	CCSA – Use of the Comprehensive Core Standard Assessment process (conducted at a minimum annually) will be the basis for an individualized care plan used by the care team to guide the treatment and management of the target sub-population.
IDN3 Youth CCSA Paper Version	CCSA – Use of the Youth Comprehensive Core Standard Assessment process (conducted at a minimum annually) will be the basis for child and adolescent individualized care plan used by the care team to guide the treatment and management of the target sub-population.
PHQ-2	The PHQ-2 provides information about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.
Clinical Institute Withdrawal Assessment for Alcohol Scale	A scale used to measure alcohol withdrawal symptoms. The scale lists ten common symptoms of alcohol withdrawal. Based on how bad a person's symptoms are, each of these is assigned a number.
Clinical Opiate Withdrawal Scale (COWS)	Rates eleven common opiate withdrawal symptoms.
Alcohol Use Disorders Identification Test (AUDIT)	Screens for harmful alcohol consumption.
Drug Use Screening Tool (DAST)	Provides a quantitative index of problems related to drug misuse.
SNHHS Patient and Family Services Recovery Care Assessment	Used in the SNHMC Emergency Department, this tool includes client demographic information (living situation, occupation/school engagement, and legal concerns), clinical evaluation, trauma/abuse evaluation, suicidal ideation and use of substances.

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

Protocol Name	Brief Description	Use (Current/Under Development)
Referral to Project IMPACT	The Project IMPACT Referral Form to services with the Student Assistance Counselor.	Current
Screening/Assessment	Project IMPACT counselor(s) complete a comprehensive intake upon referral, utilizing the CRAFFT and PHQ 2 tools to screen for substance misuse and signs of depression. The Licensed Therapist completes a CCSA screening with all children seen through office visits at the Youth Council	Current
Informed Consent and Release of Information	Intended for the youth and their parent/guardian to enable them to understand the services provided by the program (supportive counseling) and credentials of the counselors, the potential places information will be shared (other than sensitive information), the Mental Health Bill of Rights, and allows them (both youth and parent/guardian) to voluntarily sign the form, understanding they can revoke their permission at any time.	Current
Treatment/Management	Project IMPACT Contact Notes are used by the counselor for every encounter with youth, as well as with their parents/guardian, school personnel, or any other individuals related to the youth.	Current
Referral to Services/Treatment	Delivered (via secure fax/email) to any outside treatment provider or other social services support provider to support the needs of the youth.	Under Development: expected to be completed in next reporting period
Referral	Referrals are expected to come from a variety of sources, including physicians in IDN provider practices, the recovery/transitional care case managers in the SNMHC and St. Joseph Hospital emergency departments, the community-based non-treatment groups (spirituality and pre-treatment) and Greater Nashua Mental Health Center (via the IDDT program, as applicable).	Current
Emergency Department SUD Transition (SNHMC) Assessment	Emergency Department staff will contact the Recovery/Transitional Care Case Manager, who will conduct an assessment (tool(s) to be determined) and discuss with the patient the need for an appropriate level of care, as determined by ASAM criteria.	Current
Referral/Discharge Instructions	Through the use of the SUD Referrals Algorithm, referrals will be made to IDN treatment provider partners, using a closed loop referral protocol based upon the guidelines identified by the IDN Clinical Governance Committee.	Current
Closed Loop Referral Protocol	Referral protocols will utilize the "7 Principles for AI Stakeholders" from the Myers and Stauffer-provided technical assistance guide for closed loop referrals.	Under Development: expected to be completed in next reporting period

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

Project Team Member	Roles and Responsibilities
Licensed Pastoral Psychotherapist (LPP) through The Emmaus Institute	Will provide facilitation for weekly spirituality support groups for community members and their family members/caregivers to support commitment and motivation for engaging in activities that support treatment for substance use disorder (SUD). Up to 52 groups per year with 2 – 10 participants each.
Master's Level Student Assistance Counselor through The Youth Council	Identifies youth or receives referrals from school guidance counselors, administrators, Resource Officer, or nurse, engaging with the Counselor for brief intervention/education and assessment services.
SUD/Recovery Care Coordinator through Southern NH Medical Center (SNHMC)	Screens Emergency Department patients for substance use disorder and then refers to appropriate treatment.

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

See attachment_D.9a: IDN Community Project Training Plan

Project Scoring: IDN Community Project Process Milestones

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

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

Projects E: Integration Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

See attachment_E.1a IDN Community Project Implementation Plan

Implementation of Workforce Plan

The IDDT multi-disciplinary team, under the umbrella of Greater Nashua Mental Health (GNMH), was proposed to include the following roles:

- IDN Supported:
  - Team Lead/Clinical Leader (1 FTE)
  - SUD Therapist (1 FTE)
  - Mental Health Therapist (1 FTE)
  - Case Managers (2 FTEs)
  - Supported Employment Specialist (.5 FTEs)
  - Peer Support Specialist (.5 FTEs)

- Provided by GNMH:
  - Nurse (.5 FTEs)
  - Psychiatric APRN (.5 FTEs)
  - Criminal Justice Specialist/Liaison (.1 FTEs)
  - Housing Specialist (.1 FTEs)
  - Family Specialist (.1 FTEs)

As the agency learned more about the fidelity of the IDDT model through its engagement with Case Western, it discovered that due to the model's integrated focus, the separation of therapists by SUD and mental health therapy was inconsistent with the model. In addition, the consultant informed the team that having a Peer Support Specialist as part of the team is not a requirement for fidelity, so when the team struggled to find a qualified Peer Specialist despite various interviews, it was determined in collaboration with HEARTS, that the team would no longer seek a Peer Specialist. Instead, the team regularly refers to HEARTS and ReVive Recovery for Peer Support Services. Lastly, given the complexity of co-occurring disorders, it was suggested that the Medical Staff provider could be a psychiatrist or APRN, depending on experience and training. As of the end of the reporting period, the staffing model is as follows:

- IDN Supported:
  - Team Lead/Clinical Leader (1 FTE)
  - Co-Occurring Disorders Therapist (2 FTEs)
  - Case Managers (2 FTEs)
  - Support Employment Specialist (.5 FTE)

- Provided by GNMH:
  - Nurse: RN (.5 FTEs)
  - Medical Staff: Psychiatrist or psychiatric APRN (.5 FTE)

- Criminal Justice Specialist/Liaison (.1 FTE)
- Housing Specialist (.1 FTE)
- Family Specialist (.1 FTE)

IDDT Program Fidelity

The team has been working closely with Case Western throughout the project for consultation and technical assistance to implement the Fidelity Action Plan developed after the Baseline Fidelity Assessment in early 2018. A follow up Fidelity Assessment has yet to occur as the contract with IDN lead was not continued after December 2018. Case Western and GNMH continued to engage in technical assistance throughout this period in good faith that a contract would be established. However, the fidelity reassessment was unable to occur without a contract in plan. If a contract is able to be completed in July, the reassessment will be scheduled for early fall of 2019.

Training

As part of the visit for the fidelity reassessment, Case Western intended to provide another 2 days of follow up training for the entire team. As mentioned above, the fidelity reassessment was postponed, so no face to face training related to the IDDT model took place this period.

Since one factor in employee retention is employees' relationships with supervisors, with the support of the IDN, GNMH contracted with Sarah Scala Consulting to provide 3 days of training and 2 sessions of 1 on 1 coaching to various leaders throughout the organization. The IDDT Team Coordinator participated in this training.

Staff of the IDDT team also attended:

- Narcan Training: February & March
- Chronic Disease Management for Behavioral Health Providers: March
- Use of the [redacted] PreManage platform for ENS: April
- Mental Health First Aid: June
- Suicide Risk Assessment: June
- Spirituality in Behavioral Health Patient Care: An Introduction: June

Even after the IDN's contract with Case Western ended in December of 2018, the IDDT team continued to engage in monthly technical assistance calls and the Team Lead engaged in monthly supervision calls. This model of support helps the team learn more about the fidelity model recommendations and action plan by "real- time" scenarios and other dialogue with the consultant.

Clinical Protocols and Infrastructure

Clients of IDDT are screened and assessed upon admission and at least yearly thereafter. Ninety-four (94) of 100 of the clients seen in IDDT since the program began received a CCSA within the past year. GNMH protocol also requires a DLA-20 every 3 months beginning in January of 2019 and the regular use of other standardized screenings and assessments.

The team maintains daily clinical case reviews to identify and address emergent client and administrative issues. The team works through the client list, discussing who on the team last met with the client, any important clinical information, and the client's stage of treatment.

The team also reviews the Fidelity Action Plan bi-weekly with support from Case Western. During these

meetings, representatives from other programs of GNMH, such as the SUD program, InteGreat Health, Quality and Corporate Compliance, and Drug Court, also attend when applicable to discuss collaboration and support across the agency.

Technology Support:

During this period, GNMH implemented Event Notification (ENS) through [redacted] and Direct Secure Messaging. All staff were trained on the workflows. Otherwise, most information is input and stored as part of GNMH's Electronic Health Record (EHR).

E-2. IDN Community Project: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target	
		As of 12/31/18	As of 6/30/19
Number of clients served by the IDDT team	A minimum of 30 individuals from the target sub-population are served by the IDDT program by June 30, 2018.	Achieved: The maximum caseload per program fidelity has been reached at 75	Achieved in prior reporting period, however 80 clients were enrolled during the period January to June 2019 with 100 clients having been enrolled since program start
Number of clients served by the IDDT team	A minimum of 60 individuals served by the program by December 31, 2018	Achieved: The maximum caseload per program fidelity has been reached at 75	Achieved in prior reporting period, however 80 clients were enrolled during the period January to June 2019 with 100 clients having been enrolled since program start
Increased knowledge of the evidence-based IDDT fidelity model of treatment.	Up to 8 members of the IDDT team report increased knowledge of the IDDT evidence-based fidelity model of treatment for co- occurring disorders through training provided by Case Western Reserve University by June 30, 2018.	Achieved: Team participated in Case Western training in September 2018 and have participated in bi- weekly (minimum) technical assistance.	Achieved in prior reporting period, with technical assistance and regular consultation ongoing.
Increased skills in implementing the evidence-based IDDT fidelity model of treatment.	Up to 8 members of the IDDT team report increased skills in implementing the IDDT evidence-based fidelity model of treatment for co-occurring disorders, ensuring compliance with the fidelity of the program through training provided by Case Western Reserve University by June 30, 2018.	Achieved: Team participated in Case Western training in September 2018 and have participated in bi- weekly (minimum) technical assistance.	Achieved in prior reporting period, with technical assistance and regular consultation ongoing.

Increased knowledge of patient consent and privacy requirements, especially related to 42 CFR Part 2 to guide the treatment and management of the target sub-population.	Up to 8 members of the IDDT team report increased knowledge of patient consent requirements related to HIPAA and 42 CFR Part 2 to guide the treatment and management of the target sub-population through engaging in training by June 30, 2018.	Not Achieved	Achieved through all IDDT team members having attended an annual compliance training that includes requirements related to HIPPA and 42 CFR Part 2
Increased skills of the standardized process and tools for referrals, screening and assessment for the target sub-population.	Up to 8 members of the IDDT team report increased knowledge of the standardized processes and tools to meet program fidelity by June 30, 2018.	Achieved: Team participated in Case Western training in September 2018 and have participated in bi- weekly (minimum) technical assistance.	Achieved in prior reporting period, however all IDDT team members have been trained by Case Western and participate in technical assistance geared toward increasing program fidelity
Increased knowledge standardized process and tools for referrals, screening and assessment for target sub-population.	The written patient referral process is developed with support from the IDN Clinical Governance Committee and Administrative Lead, with consultation from Case Western Reserve University by February 28, 2018.	Achieved: The referral form has been further refined/improved in the EMR with community partners being education on the inclusion/exclusion criteria for IDDT in conjunction with the SUD and ACT teams, so GNMHC's array of services are being shared with partners.	Achieved in prior reporting period, with the IDDT referral form continuing to be utilized and all IDDT team members conducting a training with the ACT and SUD team to increase their knowledge about the different inclusion/exclusion criteria for the program
Increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub- population.	Up to 8 members of the IDDT team report increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub-population through education and training opportunities provided by the IDN by June 30, 2018.	Achieved: Team participated in Case Western training in September 2018 and have participated in bi- weekly (minimum) technical assistance.	Achieved in prior reporting period, with all IDDT team members having been trained by both Case Western and GNMH's Quality and Corporate Compliance on assessing case management and functional needs, as well as protocols related to care coordination
Increased knowledge of the IDN's resources to support the physical health and mental health, as well as those that support the social determinants of health, including economic, legal, educational and social, as well as housing and transportation.	Up to 3 case management meetings are held within the IDN region to support increased knowledge for the IDDT team members' treatment and support services for the target sub-population by June 30, 2018.	Achieved: The IDDT team has met with staff from InteGreat Health to conduct case management and has received training in assessing daily functioning including the social determinants of health.	Achieved in prior reporting period, with members of the IDDT team having met with InteGreat Health, Emmaus Institute, HEARTS and ReVive, in addition to attending monthly IDN meetings

Use of a standardized process and tools for referrals, screening and assessment for target sub-population.	Written protocols for patient screening and assessment are finalized with support from the IDN Clinical Governance Committee and Administrative Lead, with consultation from Case Western Reserve University by June 30, 2018.	Achieved: Completed as part of Fidelity Action Plan.	Achieved in prior reporting period and part of IDDT Fidelity Action Plan
Increased number of clients with independent living skills as a result of engagement in IDDT treatment.	Up to 30% of clients engaged in IDDT demonstrate independent living skills by December 31, 2018.	Achieved: IDDT referral form added into our EMR used internally and form Open Access at GNMH. All clients screened with ANSA and for Case Management needs	Achieved in prior reporting period with all IDDT being assessed with the ANSA and DLA-20 and receiving functional support services to improve independent living skills
Increased number of clients maintaining employment as a result of engagement in IDDT treatment.	Up to 30% of clients engaged in IDDT maintain employment by December 31, 2018.	Not Achieved: GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.	Achieved, with 23 of 80 (29%) clients seen this period being employed
Increased communication among care team members for treatment and management of the target sub-population.	New information sharing and communication platforms are incorporated into existing protocols and workflows with care team members treating clients in the IDDT program by December 31, 2018.	Achieved: Contracting and operationalization steps have been completed with [redacted] to enable the ability to receive emergency department, urgent care, and inpatient admissions, discharges and transfers (ADTs). Contracting and operationalization steps also completed with [redacted] to enable direct secure messaging (DSM).	Achieved in prior reporting period, with IDDT team members being trained and beginning to actively use workflow related to receiving emergency department, urgent care, and inpatient admissions, discharges and transfers (ADTs) through direct secure messaging (DSM) and [redacted] PreManage platforms
Increased functioning self-reported by clients engaging in IDDT treatment.	Up to 30% of clients engaged in IDDT will report improvement in functioning by December 31, 2018.	Not Achieved: GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.	Achieved, with all clients of IDDT being assessed with the ANSA and DLA-20 and receiving functional support services to work on identified functional impairments
Increased percentage of clients maintaining regular contacts with non-substance misusers.	Up to 30% more clients maintain regular contacts with non-substance misusers by December 31, 2019.	Not Achieved: GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.	Achieved, with all IDDT clients being linked to HEARTS and/or ReVive Recovery to engage in positive peer recovery oriented activities
Increased number of clients maintaining supportive housing contracts.	Up to 50% of clients engaged in IDDT maintain their supportive housing contracts as of December 31, 2019.	Not Achieved: GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.	Achieved, with 64 of 80 (80%) IDDT clients in housing. The remaining 16 are currently homeless (11 are homeless sheltered and 5 are homeless unsheltered)

Decreased number of clients incarcerated during the reporting period.	Up to 50% of clients engaged in IDDT stay out of incarceration by December 31, 2019.	Not Achieved: GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report. However, GNMH is working with the mental health court liaison to assist clients in remaining in the community.	Achieved, with only 6 of the 100 (6%) IDDT clients seen since program start reported having an arrest during the period of time reviewed. In addition, 1 client successfully graduated the MH Court program this period
Improved client experience as a result of improvements in continuum of psychiatric care.	Up to 50% of clients report improved experience with treatment by December 31, 2019.	Not achieved: DSRIP Experience of Care survey has not yet been implemented by the University of Southern Maine as part of the DSRIP Evaluation plan.	Not achieved, as the DSRIP Experience of Care survey has not yet been implemented by the University of Southern Maine as part of the DSRIP Evaluation plan
Decreased acute care visits and/or admissions as a result of engagement in IDDT treatment.	Up to 50% of clients in IDDT will not revisit hospital emergency departments or be placed in NH Hospital while engaged with IDDT integrated services by December 31, 2019.	Not Achieved: No data available at the time of publication of this report.	Achieved, with only 24 of 80 (30%) IDDT clients being seen in the ED this period and of those, only 7 of 80 IDDT clients have had multiple ED visits (9%)
Increased rate of controlled symptoms of psychosis and schizophrenia as a result of engagement in IDDT treatment.	Up to 30% of clients engaged in IDDT will report positively controlling symptoms of psychosis and schizophrenia by December 31, 2019.	Not Achieved: This will be monitored, as repeat assessments of the ANSA are not sensitive enough to distinguish. It is expected that use of the DLA 20 will provide more sensitive data to show change.	Achieved, through assessment with the DLA20, as well as increased engagement in services and medication compliance
Improved remission rate for substance use as a result of engagement in IDDT treatment.	Up to 50% of clients in IDDT are actively attaining remission from substance use by December 31, 2020.	Not Achieved: Stages of change are being tracked and clients are making changes, but GNMH is still working on quantifying this data.	Achieved, with IDDT clients progressing through treatment and reporting increased periods of sobriety
Improved provider experience as a result of reduced duplication of services across providers.	Treatment providers supporting IDDT clients will report up to 75% less duplication of services compared to the baseline (January 2018).	Not Achieved: Awaiting implementation of DSRIP Patient Satisfaction Survey through University of Southern Maine.	Not Achieved, due to DSRIP Provider Survey through University of Southern Maine not having been implemented to date
Establishment of a patient-centered integration model that moves patients to recovery and beyond illness so they can pursue a personally meaningful life.	The IDDT program will achieve up to 75% of the fidelity model characteristics (organizational and treatment) targets by December 31, 2020.	In Progress: This work continues with Case Western Reserve University, with a one- year fidelity review being completed in early 2019.	In Progress, as the contract between the IDN and Case Western ended December 2018 so the reassessment was postponed though technical assistance and consultation continues.

E-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)					
	Projected Total Need to Achieve IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18	Staffing on 6/30/19
Psychiatrist	.5	.5	5	.5	0	.5
Registered Nurse	.5	0	0	0	.5	.5
Team Leader (Licensed Therapist)	1	0	0	1	1	1
Co-Occurring Therapists (Licensed Therapist)	2	0	2	0	2	1
Case Manager	2	0	2	2	2	2
Supported Employment Specialist	.5	0	0	.5	0	.5
Peer Support Specialist	1	0	0	0	0	0
Criminal Justice Specialist/Liaison	.1	.1	.1	.1	.1	.1
Housing Specialist	.1	.1	.1	.1	.1	.1
Family Specialist	.1	.1	.1	.1	.1	.1

E-4. IDN Community Project: Budget

E4: Integrated Treatment for Co-Occurring Disorders (IDDT)

Total funding proposed by IDN partners and approved by the IDN Governance for the demonstration (2017 – 2020): $617,256.82

- CY 17 (July 2017 – December 2017): $40,784.42
- CY 18 (January 2018 – December 2018): $244,706.52
- CY 19 (January 2019 – December 2019): $165,882.89
- CY 20 (January 2020 – December 2020): $165,882.89

Total funding expended (July 2017 – December 2018): $350,941.69

- CY 17 (July 2017 – December 2017): $0
- CY 18 (January 2018 – December 2018): $136,991.69
- CY 19 (January 2019 – June 2019): $213,950.00

Projections are displayed for the July to December 2019, as well as CY 2020 and CY 2021 (January to June) in the IDN HIT Budget Table (B1-5a) at the end of this section. Below is more detail to support those budgets.

Funding Allocations/Projections

Funding associated with this project include mostly staffing-related expenses, including salary/wages and benefits, travel reimbursement, computers and cell phones, as well as office supplies and indirect costs, capped at 15% (as approved by the IDN Executive Committee).

Employee salary/wages to support:

- IDN Supported:
  - Team Lead/Clinical Leader (1 FTE)
  - Co-Occurring Disorders Therapist (2 FTEs)
  - Case Managers (2 FTEs)
  - Support Employment Specialist (.5 FTE)

- Provided by GNMH:
  - Nurse: RN (.5 FTEs)
  - Medical Staff: Psychiatrist or psychiatric APRN (.5 FTE)
  - Criminal Justice Specialist/Liaison (.1 FTE)
  - Housing Specialist (.1 FTE)
  - Family Specialist (.1 FTE)

Consultants:
- Peer Support Specialist (sub-contract with HEARTS Peer Support and Respite Center)

Supplies to support:
- office and educational
- laptops
- client needs

Travel to support:
- mileage

Current expenses to support:
- mobile phones

Indirect costs:
- capped at 15% per IDN 3 Finance Governance Committee

Funding Expenditures

The IDN implements a reimbursement only model for all funding allocations following the state fiscal year (SFY) sub-contract time frame. Consequently, during this reporting period, invoices were received for services provided during end of SFY ’18, as well as for the first half of the SFY ’19. Additionally, services were provided during the reporting period for which the IDN has not fully processed invoices. Several invoices have been received, but have not yet been reflected in the budget table below, due to the holidays and other timing issues.

Employee salary/wages and benefits:
- Team Lead/Clinical Leader (1 FTE)
- Co-Occurring Disorders Therapists (2 FTEs)
- Case Managers (2 FTEs)
- Support Employment Specialist (.5 FTE)— January, May and June only

Travel (mileage):
- Team Lead/Clinical Leader (1 FTE)
- Co-Occurring Disorders Therapists (2 FTEs)
- Case Managers (2 FTEs)
- Support Employment Specialist (.5 FTE)— January, May and June only

Current expenses (mobile phones):

- Team Lead/Clinical Leader (1 FTE)
- Co-Occurring Disorders Therapists (2 FTEs)
- Case Managers (2 FTEs)
- Support Employment Specialist (.5 FTE)— January, May and June only

Other:

- client services: “basic” needs, including groceries, records, driver’s license, prescriptions, etc.
- Indirect costs (capped at 15% per IDN 3 Finance Governance Committee)

E-4a: IDN Community Project Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	Jan - June 2019 Actuals	July - Dec 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	$291,279	$0	$0	$112,463	$178,816	$0	$0	$0	$291,279
Employee Benefits	$0	$0	$0	$0		$0	$0	$0	$0
Consultants	$57,000	$0	$0	$0		$14,250	$28,500	$14,250	$57,000
Equipment	$188	$0	$0	$0	$188	$0	$0	$0	$188
Supplies (sum of lines below)	$12,600	$0	$0	$4,436	$0	$2,041	$4,082	$2,041	$12,600
Educational	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Lab/Pharmacy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Office	$12,600	$0	$0	$4,436	$0	$2,041	$4,082	$2,041	$12,600
Travel (mileage/parking expenses)	$41,176	$0	$0	$1,148	$4,595	$8,858	$17,716	$8,858	$41,176
Occupancy	$0	$0	$0	$0	$0	$0	$0	$0	$0
Current Expenses (sum of lines below)	$2,876	$0	$0	$1,076	$1,800	$0	$0	$0	$2,876
Telephone	$0	$0	$0	$0	$1,800	$0	$0	$0	$1,800
Internet costs	$0	$0	$0	$0	$0	$0	$0	$0	$0
Postage	$0	$0	$0	$0	$0	$0	$0	$0	$0
Printing and Copying	$0	$0	$0	$0	$0	$0	$0	$0	$0
Audit and Legal	$0	$0	$0	$0	$0	$0	$0	$0	$0
Insurance	$0	$0	$0	$0	$0	$0	$0	$0	$0
Board Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Software	$0	$0	$0	$0	$0	$0	$0	$0	$0
Marketing/Communications	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Education and Training	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subcontracts/Agreements	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other (specific details mandatory):	$0	$0	$0	$0	$0	$0	$0	$0	$0
Recruitment Fees	$0	$0	$0	$0	$0	$0	$0	$0	$0
Sign-on Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Referral Bonuses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Relocation Expenses	$0	$0	$0	$0	$0	$0	$0	$0	$0
Student Loan Repayment/Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employee Recognition/Retention Bonus	$0	$0	$0	$0	$0	$0	$0	$0	$0
CMEs/Professional Development	$0	$0	$0	$0	$0	$0	$0	$0	$0
Professional Development Fees/Dues	$0	$0	$0	$0	$0	$0	$0	$0	$0
Staff Licensing/Certification Supervision Stipend	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other: please specify below	$212,138	$0	$0	$17,868	$28,551	$41,430	$82,859	$41,430	$212,138
TOTAL	**$617,257**	**$0**	**$0**	**$136,992**	**$213,950**	**$66,579**	**$133,158**	**$66,579**	**$617,257**

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

Organization/Provider	Agreement Executed (Y/N)
Greater Nashua Mental Health Center (GNMHC)	Y
HEARTS Peer Support and Respite Center	Y*
National Alliance for Mental Illness (NAMI) NH	N/A

E-6. IDN Community Project: Standard Assessment Tools

Standard Assessment Tool Name	Brief Description
Comprehensive Core Standardized Assessment (CCSA)	A Comprehensive Core Standardized Assessment (CCSA) will be completed minimally every 12 months with each client in IDDT (ideally every visit). The CCSA process addresses the following domains: demographic, medical, substance use including tobacco use (SBIRT), housing, family & support services, education, employment and entitlement, legal, risk (including suicide risk), functional status, pediatric development and depression. The IDDT team utilized its existing ANSA tool, with workflows/protocols in place for implementation by the team.
Daily Living Activities (DLA) 20 Functional Assessment	The Daily Living Activities (DLA) Functional Assessment is designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool quickly identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans.
PHQ 9	Completion of the PHQ provides the frequency of depressed mood and anhedonia over the past two weeks.
DAST (Drug Abuse Screening Test) 10	The Drug Abuse Screen Test designed to provide a brief, self-report instrument for population screening, clinical case finding and treatment evaluation research
AUDIT (Alcohol Use Disorders Identification Test)	Questionnaire method of screening for excessive drinking and alcohol use disorders.
Substance Abuse Treatment Scale (SATS)	Staged change is best understood as not a linear process (i.e. a person can move forward and backward through stages) and is measured as a function of change in observable, measurable behavior over time. Stages include Pre-Engagement, Engagement, Early Persuasion, Late Persuasion, Early Active Treatment, Late Active Treatment, Relapse Prevention, and in Remission or Recovery.
Case Management Comprehensive Assessment	Used as part of the case management continuum, the case management assessment involves the assessment of needs that inform service planning, coordination, monitoring and following, and case closure.

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

Protocol Name	Brief Description	Use (Current/Under Development)
Referral to IDDT	Drug Abuse Screening Test (DAST-10) - DAST is a 10-item brief screening tool that can be administered by a clinician or self-administered to a patient/client. Each question requires a yes or no response, and the tool can be completed in less than 8 minutes, assessing drug use (not including alcohol or tobacco) in the past 12 months.	Current
Referral to IDDT	Alcohol Use Disorders Identification Test (AUDIT) - AUDIT is a 10- item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors and alcohol-related problems.	Current
Referral and Eligibility Screening	GNMHC Intake – In August/September of 2018, GNMH implemented an Open Access process for intake into the agency. Clients can walk-in any time 4 mornings a week to be assessed using the ANSA and other tools to determine eligibility into one of the programs of the agency. Clients leave this intake appointment with a follow up appointment with a clinician in the department they are referred to or with a benefits specialist, if indicated.	Current
Referral and Eligibility Screening	Comprehensive Core Standardized Assessment (CCSA) - The CCSA will be completed at intake and at minimum every 12 months with each client in IDDT. The CCSA process addresses the following domains: demographic, medical, substance use including tobacco use, housing, family & support services, education, employment and entitlement, legal, risk (including suicide risk), functional status, pediatric development and depression.	Current
Referral and Eligibility Screening	Daily Living Activities - 20 (DLA-20) - This tool assesses theindividual on a scale of 1 - 7 (with 1 being extremely severe functional impairment with a need for paid supports and 7 being "within normal limits" (WNL) all of the time, with no impairment or problem in functioning) based upon the last 30 days in thefollowing areas: health practices, housing stability, communication, safety and managing time. This tool allows clinicians in other programs throughout GNMH to identify clients who might benefit from transferring to the IDDT team and for clinicians in the IDDT team to assess readiness for transferring to a lower level of care or transfer to an Assertive Community Treatment (ACT) Team.	Current
Referral and Eligibility Screening	American Society of Addiction Medicine (ASAM) Criteria are used to assess need for and appropriate level of care for treatment. Going through the criteria is essential to providing treatment in the least restrictive environment. Any clients being referred for Intensive Outpatient or residential SUD treatment are assessed using ASAM Criteria.	Current

Referral and Eligibility Screening	General Guidelines for Transferring Clients from One GNMHC Program to Another Tool/Protocol – All client treatment plans are reviewed quarterly in addition to conducting a DLA-20. During this review, if the client is found to be not appropriate for a certain treatment level/program, they are transferred to another GNMH (or IDN) program, using this tool/protocol.	Current
Screening and Assessment (Health Indicators)	All clients are required to attend a medical appointment at least annually even if they are not on medication. At all appointments with medical providers, physical vital signs are assessed. The IDDT Nurse uses this information and conducts motivational interviews to screen clients for: • a personal/family history of diabetes, hypertension, and cardiovascular disease • BMI • blood pressure • blood glucose or HbA1c • lipid profile • tobacco use/history • substance use/history • medication history/current medication list with dosages social supports.	Current
Screening and Assessment (Mental Health Treatment)	All clients are assessed regularly with the PHQ-9, followed by the Columbia Suicide Risk Assessment when indicated.	Current
Treatment and Management (Strengths and Needs)	Case Management Needs Assessment - Implemented through motivational interviewing by the IDDT Case Manager, this assessment serves to identify the strengths and needs to coordinate primary healthcare, housing, transportation, employment, social relationships, and community participation. It is the link between the client and care delivery system.	Current
Treatment and Management (Mental Health)	Use of stage-wise interventions are consistent with and determined by the client's stage of treatment or recovery and include engagement, motivation, action and relapse prevention.	Current
Treatment and Management (Mental Health)	Modified SATS: Stages of Treatment (Mental Illness) - Implemented by the IDDT Therapist, this assessment helps uncover the context in which symptoms of mental illness and substance use arise and intensify, as well as the ways the patient expresses and attempts to manage the symptoms.	Current
Treatment and Management	Group Therapy - Fidelity to the model identifies use of group therapy twice per week, which could include peer support, family support and other treatment-based groups.	In Progress
Treatment and Management	Connections to community-based services - Through the Clinical Case Manager as well as the IDDT Specialists (Supportive Employment, Housing, Family Support, Peer Support, Criminal Justice), clients are connected with supports needed to address barriers to recovery and relapse prevention.	Current
Treatment and Management	Ongoing case management - Ensures client is engaged with primary care, mental health and substance use treatment, as well as community-based support services as part of the treatment plan.	Current

Treatment and Management	Ongoing medication services - Medications are provided and monitored to meet the clinical treatment needs of the patient, allowing for adjustments as needed for secondary interventions for SUD non-treatment responders.	Current
Referral to higher levels of treatment	GNMHC Referral Form - If client cannot be maintained in outpatient level of care with the IDDT team, the patient will be referred to other IDN Member Entity treatment providers for residential or partial hospital treatment or to Medication Assisted Treatment (MAT) at another IDN member organization after assessment of clinical needs and contraindications.	Current

E-8. IDN Community Project Member Roles and Responsibilities

Project Team Member	Roles and Responsibilities
Team Leader/Clinical Director	Provides clinical supervision to IDDT service team members and receives referrals/intakes to determine if client meets eligibility criteria, including their ability or inability to function in the community. These could include incarceration, housing loss, frequent hospitalization, frequent use of crisis services, fractured relationships with family and friends.
Therapist (Co-Occurring Mental Health and Substance Use Disorders)	Provides direct services to support recovery from mental health symptoms including individual psychotherapy or Illness Management and Recovery (IMR), which includes systematic provision of necessary knowledge and skills through psychoeducation, behavioral tailoring, coping skills training and a cognitive behavioral approach to help clients learn to manage their illness, find their own goals for recovery and make informed decisions about their treatment. Provides relapse prevention approaches for clients to achieve long term abstinence, including managing cues to use and consequences of use, drug and alcohol refusal skills, problem-solving skills training to avoid high-risk situations, coping skills and social skills training to deal with symptoms or negative mood states related to substance abuse (e.g., relaxation training, teaching sleep hygiene, cognitive-behavioral therapy for depression or anxiety, coping strategies for hallucinations). This counseling may include individual, group and/or family therapy.
Case Manager	Assesses, monitors and links clients to other services to address needs including dental, legal, housing, etc., providing services in the community to support recovery as needed.
Supported Employment Specialist	Assists client through a vocational program that stresses competitive employment in integrated community settings and provides ongoing support.
Nurse	Supports medication compliance and monitoring of overall health through administration, monitoring, and educating about medication needed to manage diagnoses and symptoms and about other health related topics.
Psychiatrist/Psychiatric APRN	Works with the client and the IDDT team to increase medication adherence, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as clozapine, disulfiram, or naltrexone that may help reduce addictive behavior.
Criminal Justice Specialist/Liaison	Support client through legal process, if applicable.
Housing Specialist	Support the individual through the process of locating, securing, and maintaining safe and stable housing that is provided in a supervised setting that accepts clients targeted for IDDT with on-site residential staff, if needed.
Family Specialist	Builds a collaborative relationship between the treatment team and the family (or significant others) that includes basic psycho-education about serious mental illness (SMI) and its management, social support and empathy, interventions targeted to reducing tension and stress in the family, as well as improving functioning in all family members.

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

See attachment_E.9: Community Project Training Plan

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.

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

The IDN has been participating in the statewide APM meetings being facilitated by UNH and DHHS, along with the other partners around the state. We continue to engage in thinking about how we will utilize what we have learned and share updates with our IDN Governance Committees as we move into the pay-for-performance reporting.

Statewide APM Taskforce and Implementation Plan Activity	Progress	
	As of 12/31/18	As of 6/30/19
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Not Achieved: The IDN continues to work with stakeholder groups and other work teams as the statewide APM roadmap is finalized.	Not Achieved: The IDN continues to work with DHHS and the MCOs as the statewide APM roadmap is finalized.
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures	Not Achieved: The IDN continues to learn from statewide meetings and sharing information with its Governance Committees as the statewide APM roadmap is finalized.	Not Achieved: The IDN continues to learn from statewide meetings with DHHS and the MCOs and is sharing this information with its Governance Committees as the statewide APM roadmap is finalized.
Develop the financial, clinical and legal infrastructure required to support APMs	Not Achieved: The IDN continues to learn from statewide meetings and quarterly Learning Collaborative trainings, it has been working with its governance committees to develop the financial, clinical and legal infrastructure to support APMs.	Not Achieved: The IDN continues to learn from statewide meetings and quarterly Learning Collaborative trainings and has been working with its governance committees to develop the financial, clinical and legal infrastructure to support APMs, with the goal of having a model in place by the end of 2019.

Statewide APM Taskforce and Implementation Plan Activity	Progress	
	As of 12/31/18	As of 6/30/19
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	Not Achieved: The IDN continues to work with statewide groups, its governance, as well as is beginning to work with the MCOs to identify specific measures toward meeting APM goals.	Not Achieved: The IDN continues to work with statewide groups, its governance, as well as the MCOs to identify specific measures toward meeting APM goals.

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

Project Plan Implementation Attachments

PPI.a Project Plan Implementation (PPI) Implementation Plan
PPI.b Monthly Reporting Template
PPI.c Monthly Invoice Template
PPI.d Bi-weekly Training Matrix
PPI.e Monthly Project Dashboards
PPI.f Monthly Partner Performance Data Report

Status	Task Name	Comments
COMPLETE	I. Community input into IDN activities	
COMPLETE	A. Governance input on IDN 3 project implementation strategies and budget	
COMPLETE	A1. BH Workforce Capacity Building	
COMPLETE	A2. Health Information Technology (HIT)	
COMPLETE	B1	
COMPLETE	RFP Process	
COMPLETE	Form Provider Integration Work Team	
COMPLETE	Approve Initial Project Implementation Budget	
COMPLETE	Approve SFY 2019 Implementation Budget	
COMPLETE	Approve SFY 2020 Implementation Budget	
COMPLETE	C1	
COMPLETE	Clinical Governance Committee Work Team	
COMPLETE	Form CTI Work Team	
COMPLETE	Approve Initial Project Implementation Budget	
COMPLETE	Approve SFY 2019 Implementation Budget	
COMPLETE	Approve SFY 2020 Implementation Budget	
COMPLETE	D3	
COMPLETE	Clinical Governance Committee Work Team	
COMPLETE	Form D3 Work Team	
COMPLETE	Approve Initial Project Implementation Budget	
COMPLETE	Approve SFY 2019 Implementation Budget	
COMPLETE	Approve SFY 2020 Implementation Budget	
COMPLETE	E4	
COMPLETE	Clinical Governance Committee Work Team	
COMPLETE	Form E4 Work Team	
COMPLETE	Approve Initial Project Implementation Budget	
COMPLETE	Approve SFY 2019 Implementation Budget	
COMPLETE	Approve SFY 2020 Implementation Budget	
COMPLETE	Network Development	
COMPLETE	Full IDN Meetings	
COMPLETE	2017 Mee ings	
COMPLETE	2018 Mee ings	
COMPLETE	2019 Mee ings	
COMPLETE	IDN presentations/workshops in the community	
COMPLETE	IDN 3 Behavioral Health Conference	
COMPLETE	IDN Member Entities	
COMPLETE	IDN 3 B1 Cherokee Health Kick-off Event	
COMPLETE	IDN Career Fair	
	Addressing the Opioid Crisis	
COMPLETE	Governance	
COMPLETE	Inaugural Governance Committee Members start	
COMPLETE	Executive Governance Committee	
COMPLETE	2017 Meetings	
COMPLETE	2018 Meetings	
COMPLETE	2019 Meetings	
COMPLETE	Finance Governance Committee	
COMPLETE	2017 Meetings	
COMPLETE	2018 Meetings	
COMPLETE	2019 Meetings	
COMPLETE	Clinical Governance Committee	
COMPLETE	2017 Meetings	
COMPLETE	2018 Meetings	
COMPLETE	2019 Meetings	
COMPLETE	Data/IT Governance Committee	
COMPLETE	2017 Meetings	
COMPLETE	2018 Meetings	
COMPLETE	2019 Meetings	
COMPLETE	Community Engagement Governance Committees	
COMPLETE	2017 Meetings	
COMPLETE	2018 Meetings	
COMPLETE	2019 Meetings	
COMPLETE	Governance Committee Work Teams	
COMPLETE	Clinical Committee	
COMPLETE	CCSA/Universal Screening Work Team	
COMPLETE	Information Sharing, Standardized Protocols and Workflows	
COMPLETE	2017 Meetings	
COMPLETE	2018 Meetings	
COMPLETE	2019 Meetings	

COMPLETE	Statewide IDN Shared Care Plan Task Force	
COMPLETE	Patient Consent and Privacy Work Team	
COMPLETE	Provider Practice Integra ion Work Team	
COMPLETE	Internal Provider and Workforce Training Work Team	
COMPLETE	Clinical/HIT Combo	
COMPLETE	Health Integration Technology (HIT) Implementation to Support Integration	
COMPLETE	Performance Metrics and Quality Monitoring	
COMPLETE	Reporting Tools and Data Analysis	
COMPLETE	Budget	
COMPLETE	IDN 3 Capacity Building Budget Approval	
COMPLETE	IDN 3 2017 - 2020 Implementation Plan Preliminary Draft Budget Approval	
COMPLETE	A1: Behavioral Health Workforce Capacity Development	
COMPLETE	A2: Health Information Technology	
COMPLETE	B1: Integrated Health	
COMPLETE	C1: Critical Time Intervention	
COMPLETE	D3: Expansion in SUD Treatment Options	
COMPLETE	E4: Integrated Dual Diagnosis Treatment (IDDT)	

	Reporting Deliverable	Progress	Barriers	Comments
IDN-funded Workforce: hiring/onboarding and vacancies				
1 FTE XXXXX 2 FTE XXXXX	# and role of IDN-funded staff recruited/onboarded during month vs. projected			
	# and role of IDN-funded staff trained during month vs. projected			
	# and role of IDN-funded positions vacant during month			
IDN attributed Medicaid beneficiaries served by organization and/or program				
	# of Medicaid beneficiaries served this month vs projected			
	# of IDN Medicaid beneficiaries and/or total clients served by program since program/strategy began			
Projected Target (Jan - June 2019): 37.5% of Medicaid beneficiaries ages 12 and older seen in an office visit by an IDN treatment provider (primary care, mental health or SUD treatment provider).	# of IDN Medicaid beneficiaries completing the CCSA process during month vs projected			
	# of Medicaid beneficiaries scoring positive on any of the CCSA domains during the month (note domain they screened positive for)			
Projected Target (Jan - June 2019): 40% of Medicaid beneficiaries screening positive for depression in an office visit with an IDN treatment provider (primary care, mental health or SUD treatment) have an appropriate follow-up documented.	# of Medicaid beneficiaries scoring positive on depression screening during the month			
Projected Target (Jan - June 2019): 40% of Medicaid beneficiaries screening positive for potential substance use disorder (SUD) in an office visit with an IDN treatment provider (primary care, mental health or SUD treatment) have an appropriate follow-up documented.	# of Medicaid beneficiaries scoring positive on substance use disorder (SUD) screening during the month (note type of substance misuse they screened positive for)			
Projected Target (Jan - June 2019): 40% of Medicaid beneficiaries who are smokers and seen in an office visit by an IDN treatment provider (primary care, mental health or SUD treatment) receive smoking and tobacco cessation screening and counseling.	# of Medicaid beneficiaries scoring positive on smoking and tobacco cessation during the month			
	# of Medicaid beneficiaries with positive screening referred out for additional assessment or treatment			
	referral sources for follow-up services (note to whom and how many per referral source)			
	# of follow-up referrals implementing a closed loop protocol/workflow, following the IDN 3 guidelines			
	referral sources into organization (note from whom and how many per referral source)			
Projected Target (Jan - Dec 2019): (HOSP_ED.01) reduction from (2015) baseline of 8.4% to December 2019 target of 7.9% of Medicaid beneficiaries with BH diagnoses with frequent (4+ visits per year) and (HOSP_ED.02) reduction from (2015) baseline of 15.07% to December 2019 target of 14.18% with selected avoidable emergency department visits.	# of IDN attributed Medicaid beneficiaries with documented frequent (4+ per year) emergency department visits			
Projected Target (Jan - Dec 2019): (HOSP_IP.01) reduction in adult Medicaid beneficiaries with BH diagnoses with readmission to any hospital for any cause within 30 days.	# of IDN attributed Medicaid beneficiaries with a readmission to hospital inpatient services within 30 days during the current month			
	IDDT team continues to engage in technical assistance provided by Case Western Reserve University to support achieving program fidelity			
Progress to SFY '19 targets identified in sub-contract SOW				
	Targeted number of attributed patients/individuals served by the end of the sub- contract period: up to XXXX.			

	When available, [redacted] with tracking and monitoring referrals and follow-up plans using the closed loop referral protocols identified and approved by the IDN.			
	All XXXX clients will have a housing plan that includes both immediate and long-term housing plans			
	Up to 30% of clients engaged in XXXX maintain employment by December 31, 2018.			
Trainings completed by IDN-funded and/or identified MDCT members.				
	MDCT member trainings completed, outlined by individual team member (PCP, BH provider, psychiatrist, care coordinator/case manager) in: - Universal Screening - Understanding Addiction - Care Coordination - Co-Occurring Disorders - Cultural Competency - Mental Health Awareness/First Aid			
	Non- direct care staff member trainings completed, outlined by role: - Mental Health Awareness/First Aid - Issues in Coding/Billing			
	Discipline/license-specific trainings completed by IDN-funded staff, outlined by individual/role			
Success story of the month: please share with us a "real-life experience" that demonstrates a change in process or an outcome from the workforce capacity building, information sharing, and/or workflow/protocol changes due to the efforts of this DSRIP Demonstration Waiver. We share these stories with DHHS on a weekly basis, but also plan to share them with other stakeholders to help them better understand the work of the IDN.				
	Who was impacted/affected in your "real-life experience?"			
	How were they impacted/affected?			
	Why do you attribute this impact to the efforts/strategies funded by the IDN?			
	What lessons learned would you want to share with others around the state about this experience?			

IDN 3 Reimbursement Template and Budget Tracking Form

Organization: XXXXXXXXXX

Project Name and IDN Project Funding Source (A1, A2, B1, C1, D3, E4): XXXXXXXXXX

Invoice for Reimbursement: Month/Year

Budget Period: July 1, 2018 - June 30, 2019

IDN Internal Use Only	Line Item	MONTHLY ACTUALS	APPROVED SFY '19 ANNUAL BUDGET	BUDGET - ACTUAL
74380	1. Employee Salary/Wages	$0.00	$0.00	$0.00
74380	2. Employee Benefits	$0.00	$0.00	$0.00
75014	3. Consultants	$0.00	$0.00	$0.00
73050	4. Equipment Rental	$0.00	$0.00	$0.00
73111	4. Equipment Repair and Maintenance	$0.00	$0.00	$0.00
73095	4. Equipment Purchase / Depreciation	$0.00	$0.00	$0.00
75030	5. Supplies Education	$0.00	$0.00	$0.00
75038	5. Supplies Medical/Lab/Pharmacy	$0.00	$0.00	$0.00
75025	5. Supplies Office	$0.00	$0.00	$0.00
75036	6. Travel (mileage/parking expenses)	$0.00	$0.00	$0.00
75019	7. Occupancy	$0.00	$0.00	$0.00
73130	8. Current Expenses Telephone	$0.00	$0.00	$0.00
75001	8. Current Expenses Internet Costs	$0.00	$0.00	$0.00
75010	8. Current Expenses Postage	$0.00	$0.00	$0.00
74370	8. Current Expenses Printing and Copying	$0.00	$0.00	$0.00
74340	8. Current Expenses Audit and Legal	$0.00	$0.00	$0.00
77000	8. Current Expenses Insurance	$0.00	$0.00	$0.00
75017	8. Current Expenses Board Expenses	$0.00	$0.00	$0.00
75002	9. Software	$0.00	$0.00	$0.00
75026	10. Marketing/Communications	$0.00	$0.00	$0.00
74395	11. Staff Education and Training	$0.00	$0.00	$0.00
73120	12. Subcontracts/Agreements	$0.00	$0.00	$0.00
	13. Other (specific details mandatory):			
75016	Workforce Recruitment: Recruitment Fees	$0.00	$0.00	$0.00
71115	Workforce Recruitment: Sign-on Bonus	$0.00	$0.00	$0.00
70007	Workforce Recruitment: Staff Referral Bonuses	$0.00	$0.00	$0.00
71095	Workforce Retention: Student Loan Repayment/Reimbursement	$0.00	$0.00	$0.00
71115	Workforce Retention: Employee Recognition/Retention Bonus	$0.00	$0.00	$0.00
71045	Workforce Retention: CMEs/Professional Development	$0.00	$0.00	$0.00
75018	Workforce Retention: Professional Development Fees/Dues	$0.00	$0.00	$0.00
70008	Staff Licensing/Certification Supervision Stipend	$0.00	$0.00	$0.00
	DIRECT TOTAL	**$0.00**	**$0.00**	**$0.00**
75037	**INDIRECT TOTAL : As A Percent of Direct Costs**	$0.00	$0.00	$0.00
	TOTAL:	$0.00	$0.00	$0.00

[1] **Allocation Method for Indirect/Fixed Cost is 15% of Direct Incremental Expense**

Address

Mail Check to:

IDN3 Upcoming Training Opportunities
May 24, 2019

Category	Training	Description/Learning Objectives	Date/ Time	Audience	Format	CEUs	For More Information and to Register
Understanding Addiction							
	NH Substance Related and Addictive Disorders Module 6: Inhalant related Disorders	Attendees receive an overview of DSM-5 criteria and diagnostic information specific to Inhalant-Related Disorders. In addition, the course teaches the alterations that substance use may make to important brain areas needed for life-sustaining functions.	6/19/19 10-11:30am	Providers	webinar	1.5	https://attendee.gototraining.com/r/5463836514721741825
	SBIRT for Providers	Providers discuss the conceptual framework of SBIRT as a public health model and its impact as a system change initiative. Practice for applying concepts to provide screenings, brief interventions, and referrals to treatment will be included.	6/27/19 1 - 3pm	providers	webinar	2	https://attendee.gototraining.com/r/2034733526097795586
	New England School of Addiction Studies	A four-day intensive experience to further knowledge, skills, and experience in the field of substance use disorder services; nearly 100 courses are offered; this training opportunity will provide much of the required courses/credits towards MLADC certification; one of the identified goals in the IDN project plans is to increase the number of MLADCs in our workforce, so we have training funds available to support this opportunity	6/3/19 – 6/6/19	those working towards MLADC certification	in-person Worcester St University		New England School of Addiction Studies; to request IDN funding, email Michele (michele.craig@snhhs.org) with the information for who from your organization is proposed to attend and a budget that includes your associated expenses
Co-Occurring Disorders							
	IDN1: Diabetes Hyperglycemia	Diabetes Overview for All (Dr. Charles Brackett)	flexible; 20 minutes	BH, Social Service	pre-recorded webinar	n/a	https://tinyurl.com/yxbmn6t6

	IDN1: Diabetes, Hypertension, Dyslipidemia	Chronic Disease Management for BH Providers – Diabetes, Hypertension & Dyslipidemia (Tracy Tinker)	**flexible; 1 hour**	BH, Social Service	pre-recorded webinar	n/a	https://tinyurl.com/yxbmn6t6
	IDN4/Rivier University: Chronic Disease Lunch n Learn Series	*Diabetes*	**flexible; 40 minutes**	BH, Social Service	pre-recorded webinar	n/a	Click here to view the training.
	IDN4/Rivier University: Chronic Disease Lunch n Learn Series	*Hyperlipidemia*	**flexible; 30 minutes**	BH, Social Service	pre-recorded webinar	n/a	Click here to view the training.
MH First Aid/MH Awareness							
	Mental Health First Aid	Mental Health First Aid teaches you **how to identify, understand and respond to signs of mental illnesses and substance use disorders**. This 8-hour training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to appropriate care.	6/13/19 8am-5pm	Employers, Police Officers, Hospital Staff, First Responders, Faith Leaders	In person Greater Nashua Mental Health 100 W. Pearl St Nashua	n/a	Mental Health First Aid
	IDN2: Mental Health Awareness Presentation	"Working in an Integrated Primary Care Practice", an IDN2 developed resource for indirect staff to introduce why it can be difficult for those with behavioral health needs to access and stay engaged in treatment and the cultural shifts and practice changes necessary to integrate care. (upon completion, please link to the survey mentioned at the end of the presentation so we can report who has completed the training)	**flexible**	indirect service staff	online presentation materials	n/a	https://region2idn.com/resources/
	IDN1: Mental Health Awareness	MH Awareness (Phil Wyzik)	**flexible; 45 minutes**	Primary Care staff	pre-recorded webinar	n/a	https://tinyurl.com/yxbmn6t6
Cultural Competency							

	Lunch and Learn: Substance Use Disorder and Culture	☐ hear insider information from a person in recovery who now works as a Recovery Specialist. ☐ hear how effective communication with clients experiencing substance use disorder is part of general cultural effectiveness.	at your location; your date; 1 hour	practice team members, nurses, nurse practitioners, physicians, physician assistants, social workers, admin staff	in person at your location	n/a	Contact Lynn Clowes at Ascentria Care Alliance at LClowes@ascentria.org
Miscellaneous							
	Community Health Worker Summit	• HW Certification: Pathways & Decisions • Breakouts: CHW and Stakeholder sessions • CHW Initiatives in NH • National CHW Initiative; Core Consensus Project • NH CHW Coalition and Award • A Mother's Story: Journey to Becoming an Advocate	6/26/19 8:30am-4pm	CHWs, patient navigators, case managers, those who work in community health, social service, and community organizations	In person Grappone Center 70 Constitution Ave Concord	5.5	Register or to request IDN funding, email Michele (michele.craig@snhhs.org)
	Suicide Risk - A Clinical Perspective - Module 1 - Suicide Risk Overview	Clinicians learn to identify warning signs and risks of suicide. They also learn about protective factors, which ensure vulnerable people are supported and connected with others during difficult times, thus making suicidal behaviors less likely.	6/3/19 10am - 12pm	clinicians	webinar	2	https://attendee.gototraining.com/r/6427559555953595650
	Suicide Risk - Module 2 - Assessment, Intervention and Evidence Based Treatment	To help prevent suicide, providers and clinical staff learn assessment tools to screen for depression, anxiety and alcohol use, all of which can increase suicide risk. This course also covers evidenced-based treatment interventions.	6/11/19 1 - 3pm	clinicians	webinar	2	https://attendee.gototraining.com/r/6538601434290753793
	Introduction to Spirituality in Patient Care: How the Mind, Body and Spirit are Interconnected in Healing Physical	This introductory presentation will raise awareness and understanding of the dynamics and impact of spirituality in the overall care of patients. Participants will leave with a better understanding of why looking at a person as a "living document" provides opportunities for treating the whole person and will have increased knowledge of available screening and assessment tools.	at your location; your date; 50 minutes	BH, Social Service, Primary Care staff	in person at your location	n/a	Contact Dr. Manseau at The Emmaus Institute at corpuspensions@gmail.com

	and Behavioral Health Conditions						

IDN 3 DSRIP Demonstration Waiver Executive Summary

Overall Status: Week Ending: 7/5/19 Y

Admin Team: L. Madden, M. Craig, J. Sarkar, B. Sheehan, T. Solomon

Project Objectives

1. Deliver integrated physical & behavioral health care that better addresses the full range of individuals needs
2. Expand capacity to address emerging & ongoing behavioral health needs in appropriate setting
3. Reduce gaps in care during transitions across care settings by improving coordination across providers & linking patients with community supports
4. Move 50% of Medicaid reimbursement to Alternative Payment Models

Project Risks/Issues

Issue: Complete reporting (to the IDN and [redacted] is not being delivered monthly
Impact: Lack of visibility impacts meeting deliverables/DHHS-set targets for Semi-Annual Report (SAR) and DSRIP Outcome Measures

Mitigations to Project Risks

Mitigation: Admin Lead has pre-populated a Monthly Report Template for partners to submit by the 7th of every month (along with invoices) that includes common reporting information needed, as well as project and/or sub-contract Scope of Work specific information

Mitigation: IDN Admin Lead is sharing data [redacted] it has access to on a monthly basis to increase visibility of what measures are (and aren t) being reported month-to—month as we approach reporting deadlines to DHHS (6-month or 12-month)

Project Work Streams

Work Stream	Status
Workforce Capacity Building	G
Information Sharing Implementation	Y
Integrated Health Implementation	Y
Care Transitions Implementation	Y
Expansion in SUD Treatment Options Implementation	R
Co-Occurring Disorders Implementation	Y

Status: On Track G Minor issues/critical path recovery feasible Y Major issues/critical path at risk R Complete C Not Started N

IDN 3 DSRIP Demonstration Waiver Integrated Health Implementation by Partner

Status: Week Ending: 7/5/19 R

CCSA Implementation/ Operationalized	[redacted] Operational	Event Notification	Closed Loop Referral	Shared Care Plan Implementation	Access to Multi-Disciplinary Team	Partner
R	G	Y	R	R	G	Dartmouth Hitchcock
G	G	Y	R	R	R	Emmaus Institute
G	Y	R	R	R	R	Foundation Medical Partners
G	G	G	R	R	R	Greater Nashua Mental Health Ctr
G	G	G	G	R	G	InteGreat Health
R	G	G	G	R	G	Lamprey Health
R	R	R	R	R	R	Merrimack River Medical
R	R	R	R	R	R	Partnership for Successful Living
○	R	R	○	○	○	St. Joseph Hospital
R	Y	R	R	R	R	St. Joseph Physician Practices
○	G	G	○	○	○	Southern NH Medical Center
G	G	G	R	R	R	The Youth Council

Status G On Track Y In process but delayed R Major issues/critical path at risk C Complete N Not Started ☐ Not applicable

Greater Nashua IDN

IDN 3 DSRIP Demonstration Waiver
Health Information Technology Implementation Status by Partner

NH DSRIP

SFY 19 A2 Sub-Contract Execution	NIST Assessment Scheduled	NIST Assessment Complete	NIST Attestation Received	CMT Contract Completion	CMT Patien File Uploaded	CMT User Training Complete	CMT Installation Complete	Kno2 Admin On-Boarding & Training Completion	Kno2 User On-Boarding & Training Completion	DSM Attestation Received or Testing Complete	2019 MAeHC Reporting	Organization
On Track	04/08/19	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	In Progress, but Delayed	Not Applicable	Ascentria Care Alliance
On Track		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	On Track	On Track	Not Started/ At Risk	Not Applicable	Department of Public Health - City of Nashua
On Track		On Track	Not Started/ At Risk	On Track	On Track	Not Applicable	On Track	On Track	On Track	Not Started/ At Risk	Not Applicable	Crotched Mountain
On Track		On Track	On Track	In Progress, but Delayed	Not Started/ At Risk	Not Started/ At Risk	In Progress, but Delayed	Not Applicable	Not Applicable	In Progress, but Delayed	In Progress, but Delayed	Dartmouth Hitchcock Nashua
On Track		On Track	On Track	In Progress, but Delayed	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Not Applicable	On Track	In Progress, but Delayed	Foundation Medical Center
On Track		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Gateways Community Services
On Track	04/26/19	On Track	On Track	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	On Track	Not Started/ At Risk	Not Applicable	Granite State Independent Living (GSIL)
On Track	06/14/19	In Progress, but Delayed	Not Started/ At Risk	On Track	On Track	On Track	On Track	On Track	On Track	In Progress, but Delayed	On Track	Greater Nashua Mental Health Center
On Track	07/01/19	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable	On Track	On Track	Not Started/ At Risk	Not Applicable	HEARTS Peer Support Center
On Track		Not Applicable	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	Not Applicable	Home Health and Hospice
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Hillsborough County Corrections and Nursing Home
On Track		Not Applicable	On Track	On Track	On Track	On Track	On Track	On Track	On Track	In Progress, but Delayed	On Track	Lamprey Health
On Track	04/29/19	On Track	On Track	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Life Coping
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Merrimack River Medical Services
On Track	02/08/19	On Track	On Track	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	On Track	On Track	On Track	Not Applicable	National Alliance on Mental Illness (NAMI) New Hampshire
In Progress, but Delayed		Not Applicable	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Partnership for Successful Living (Harbor Homes, Keystone Hall, Healthy at Home)
On Track	07/01/19	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Revive Recovery Center
On Track		Not Applicable	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	Southern NH Medical Center
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Southern NH Services
Not Started/ At Risk		Not Applicable	Not Applicable	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	St. Joseph Community Services
On Track		Not Applicable	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	St. Joseph Hospital and Physician Practices
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	YMCA
On Track	05/15/19	On Track	Not Started/ At Risk	On Track	In Progress, but Delayed	Not Started/ At Risk	Not Started/ At Risk	On Track	On Track	Not Started/ At Risk	On Track	The Emmaus Institute
On Track	02/07/19	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	Not Started/ At Risk	On Track	Youth Council

- On Track
- In Progress, but Delayed
- Not Started/ At Risk
- Not Applicable

Appendix

Greater Nashua IDN

NH DSRIP

IDN 3 DSRIP Demonstration Waiver
A1: Behavioral Health Capacity Building

Overall Status: Week Ending: 7/5/19 Y

Recent Accomplishments

Ascentria, Dartmouth Hitchcock and Lamprey all hired Community Health Workers via IDN funding and are in various stages of onboarding.

Project Issues/Risks

Issue: Continued minimal participation by MDCT members in training in support of DHHS requirements
Impact: Potential reduced funding to the IDN

Mitigation to Risks

1. IDN monthly reporting template requires MDCT member training participation to be reported by 7th of month, along with invoices for reimbursement

Project Deliverables

Deliverable	Key Driver to Status	Status
Participation in Statewide Behavioral Health Workforce Capacity Taskforce	Recruitment/Hiring subcommittee engaged in statewide peer support behavioral health career paths, development of healthcare job catalog	G
Workforce Recruitment & Hiring	Continued progress in filling IDN-funded clinical positions; some key positions still unfilled	Y
Workforce Retention & Sustainability	In general, IDN funded positions have been stable for staff retention	G
Workforce Training & Education	Transition to webinar based training (vs in person) is improving attendance but MDCT member participation is still lacking	R
Spending to Budget	Partner invoicing has become more timely and detailed	G

Status: G On Track Y In process but delayed R Major issues/critical path at risk C Complete N Not Started

A2: Health Information Technology to Build Infrastructure

Status: Week Ending: 07/05/19 Y

Recent Accomplishments

1. Presented DSRIP Outcome Measure reporting for May to Governance Committees & Partners; will send out June wk of 07/08/19; Direct Secure Messaging (DSM): DSM & Integrated DSM attestations via send/receive testing in progress – will result in publication of IDN 3 regional partner DSM IDs;
2. NIST Cybersecurity Assessment: In the pipeline for July:, Revive & H.E.A.R.T.S;
3. Event Notification/Shared Care Plan [redacted] continue to make progress in implementation & operationalization of ENS with several partners now up and running
4. IDN sub-contracting: Gateways has now executed A2 sub-contracting with several partners still moving along in pending status
5. A2 SAR component initial review by DHHS complete – feedback very positive with new presentation

Project Issues/Risks

Issue: IDN sub-contracting, including BAA/QSOA and DUA still in progress for PSL, MRMS, LaMora,, NHH, SNHS, YMCA
Result: Performance outcome measure reporting delayed with several partners and moving forward with NIST, [redacted] and [redacted] contracting subsequently delayed to FY20;
Issue: June 19 deadlines passed: [redacted] 2018 calendar year measures were due by 06/15/19 & FY19 closure was 06/30/19; STJ delayed in [redacted] reporting due to internal barriers as well as others not achieving min. HIT requirements
Result: Achieving IDN goals directly related to funding may be delayed or not achieved.

Mitigation to Risks

1. Simplified IDN sub-contracting process to address partner concerns
2. Liaisons working with partners with their Work Plans, sub-contracting execution, data reporting & data gap analytics

Project Deliverables

Deliverable	Key Driver to Status	Status
Minimum for all PCP/MH/SUD partners: Data Extraction/Validation for DHHS Reporting & IDN 3 Performance Measure Reporting	• Data aggregation reporting [redacted] & IDN Admin Lead Portal Access - need DUA*	Y
Minimum for all partners: Secure Data Storage & Internet Connection Capabilities	• NIST/HIPAA review ability to secure PHI through technology and ability to securely connect to the internet - need DUA*	Y
Minimum for all partners who are HIPAA-covered Entities: Event Notification (ENS) Generation, Transmission and Reception & Shared Care Plan (SCP)	• [redacted] Pre-Manage ED & Pre-Manage ENS implementation - need DUA*	Y R
Minimum for all partners: Direct Secure Messaging (DSM)	• Built-in EHR capabilities or [redacted] DSM platform - need DUA*	

**DUA – Data Use Agreement*

Status: G On Track Y In process but delayed R Major issues/critical path at risk C Complete N Not Started

IDN 3 DSRIP Demonstration Waiver
B1: Integrated Health

Status: Week Ending: 7/5/19 R

Recent Accomplishments

1. 36 (73%) of practice partners completion of the Site Standardized Assessment with Citizens Health Initiative (CHI)

Project Issues/Risks

Issue: SAR report writing highlights delays in B1 progress towards Coordinated/Integrated Care with no partner meeting the requirements for either
Impact: Lack of "met" for most 6/30/19 and 12/31/18 write-back deadlines will result in negative impact to funding
Issue: Delay in funding approval for clinical consultant resulted in missed 6/30/19 deadline for development of a regional multi-disciplinary core team
Impact: Will result in negative impact to funding

Mitigation to Risks

1. Focus on gaining "met" on missed deadline items by 12/31/19 when final opportunity for funding make-up expires

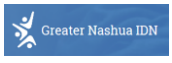
Project Deliverables

Deliverable	Key Driver to Status	Status
Current state and progress of achieving Coordinated Care Practice designation	Kicked off annual Site Self-Assessments (SSAs)	G
Use of CCSA process and/or universal screening at least annually	Limited IDN partner member submissions of ***monthly*** CCSA execution and outcomes data to [redacted] minimal execution of CCSAs	R
Operationalization of Multi-Disciplinary Core Team (MDCT); Monthly case management meetings in place	Limited partner member PCP organizations required identification of MDCT members and BH provider access to MDCT; committed to 10 MDCT teams; 3 in place	Y
Diagnosis, treatment, and management of care info regularly shared through documented workflows/protocols	IDN3 approved guidelines & protocols distributed to member partners; awaiting attestation of documented & operationalized within member partner organizations	R
Use of technology to identify at-risk patients, plan care, and ensure closed loop referrals	Increase in partner member contracting with vendors and operationalization of DSM and ENS/SCP	R

Status: G On Track Y In process but delayed R Major issues/critical path at risk C Complete N Not Started

Delivery System Reform Incentive Payment (DSRIP)
NH Building Capacity for Transformation
1115 Waiver
IDN 3: The Greater Nashua Region

Partner Monthly Performance/Status Data
For June (data available as of July 08, 2019)



IDN 3 Partner Engagement

IDN Partners: PCP Services

- **Dartmouth Hitchcock** (DH)
  - DH Nashua Family Medicine
  - DH Nashua Internal Medicine
  - DH Hudson
  - DH Merrimack
  - DH Milford
  - DH Nashua Pediatrics

  ~7500 attributed lives

- **St. Joseph Hospital & Physician Practices** (SJH)
  - SJH Pediatrics Nashua
  - SJH Pediatrics Milford
  - SJH Pediatrics Sky Meadow
  - SJH Family Medicine, Nashua
  - SJH Internal Medicine
  - SJH Family Medicine and Specialty Services Hudson
  - SJH Family Medicine and Specialty Services Merrimack
  - SJH Family Medicine and Specialty Services Milford
  - SJH Adult Medicine

  ~4600 attributed lives

- **Foundation Medical Partners** (FMP)
  - FMP Amherst Family Practice
  - FMP Downtown Medical Associates
  - FMP Hudson Family Practice
  - FMP Milford Family Practice
  - FMP South Nashua Family Practice
  - FMP Internal Medicine Associates of Nashua
  - FMP Merrimack Medical Center
  - FMP Nashua Primary Care
  - FMP Nashua West Adult Medicine
  - FMP Pelham Family Medicine
  - FMP Internal Medicine at Pelham Medical Center
  - FMP Medicine-Pediatrics of Nashua
  - FMP Foundation Pediatrics
  - FMP Main Street Pediatrics and Adolescent Medicine
  - FMP Internal Medicine

  ~9000 attributed lives

- **Lamprey Health**
  ~2000 attributed lives

- **Harbor Homes**
  ~2000 attributed lives

IDN 3 Attributed Medicaid Population: 24,068

IDN Partners: MH & SUD Services

- **Greater Nashua Mental Health**
- **Keystone Hall**
- **LaMora Psychological Associates**
- **Merrimack River Medical Services**
- **The Emmaus Institute**
- **The Youth Council**

IDN Partners: Support Services

- **Ascentria Care Alliance**
- **Department of Public Health**
- **Crotched Mountain**
- **Gateways Community Services**
- **Granite State Independent Living**
- **H.E.A.R.T.S. Peer Support**
- **Hillsborough County**
- **Home Health and Hospice**
- **Life Coping**
- **NAMI NH**
- **Revive Recovery Center**
- **Southern NH Services**
- **St. Joseph Community Services**
- **YMCA**

IDN 3 DSRIP Demonstration Waiver
HIT Implementation Status by Partner as of 07/08/19

SFY 19 A2 Sub-Contract Execution	NIST Assessment Scheduled	NIST Assessment Complete	NIST Attestation Received	CMT Contract Completion	CMT Patient File Uploaded	CMT User Training Complete	CMT Installation Complete	Kno2 Admin On-Boarding & Training Completion	Kno2 User On-Boarding & Training Completion	DSM Attestation Received or Testing Complete	2019 MAeHC Reporting	Organization
On Track	04/03/19	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	In Progress, but Delayed	Not Applicable	Ascentria Care Alliance
On Track		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	On Track	On Track	Not Started/ At Risk	Not Applicable	Department of Public Health - City of Nashua
On Track		On Track	Not Started/ At Risk	On Track	On Track	Not Applicable	On Track	On Track	On Track	Not Started/ At Risk	Not Applicable	Crotched Mountain
On Track		On Track	On Track	In Progress, but Delayed	Not Started/ At Risk	Not Started/ At Risk	In Progress, but Delayed	Not Applicable	Not Applicable	In Progress, but Delayed	In Progress, but Delayed	Dartmouth Hitchcock Nashua
On Track		On Track	On Track	In Progress, but Delayed	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Not Applicable	On Track	In Progress, but Delayed	Foundation Medical Center
On Track		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Gateways Community Services
On Track	04/26/19	On Track	On Track	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	On Track	Not Started/ At Risk	Not Applicable	Granite State Independent Living (GSIL)
On Track	06/14/19	In Progress, but Delayed	Not Started/ At Risk	On Track	On Track	On Track	On Track	On Track	On Track	In Progress, but Delayed	On Track	Greater Nashua Mental Health Center
On Track	07/01/19	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Not Applicable	Not Applicable	Not Applicable	On Track	On Track	Not Started/ At Risk	Not Applicable	HEARTS Peer Support Center
On Track		Not Applicable	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	Not Applicable	Home Health and Hospice
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Hillsborough County Corrections and Nursing Home
On Track		Not Applicable	On Track	On Track	On Track	On Track	On Track	On Track	On Track	In Progress, but Delayed	On Track	Lamprey Health
On Track	04/29/19	On Track	On Track	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Life Coping
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Merrimack River Medical Services
On Track	02/08/19	On Track	On Track	On Track	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	On Track	On Track	On Track	Not Applicable	National Alliance on Mental Illness (NAMI) New Hampshire
In Progress, but Delayed		Not Applicable	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Partnership for Successful Living (Harbor Homes, Keystone Hall, Healthy at Home)
On Track	07/01/19	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Revive Recovery Center
On Track		Not Applicable	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	Southern NH Medical Center
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	Southern NH Services
Not Started/ At Risk		Not Applicable	Not Applicable	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	St. Joseph Community Services
On Track		Not Applicable	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	St. Joseph Hospital and Physician Practices
Not Started/ At Risk		Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Started/ At Risk	Not Applicable	YMCA
On Track	05/15/19	On Track	Not Started/ At Risk	On Track	In Progress, but Delayed	Not Started/ At Risk	Not Started/ At Risk	On Track	On Track	Not Started/ At Risk	On Track	The Emmaus Institute
On Track	02/07/19	On Track	On Track	On Track	On Track	On Track	On Track	On Track	On Track	Not Started/ At Risk	On Track	Youth Council

- On Track
- In Progress, but Delayed
- Not Started/ At Risk
- Not Applicable

Greater Nashua IDN

3

NH DSRIP

Outcome Measure Reporting Details

([redacted]

Greater Nashua IDN

NH DSRIP

Outcome Measure Reporting Schedule for 2019

1. ASSESS SCREEN 1: Use of Comprehensive Core Standardized Assessment Covering 10 domains including medical, housing, legal, employment, etc
2. ASSESS SCREEN 2: Follow-up plan for positive screenings for SUD and/or Depression
3. ASSESS SCREEN 4: Smoking and tobacco cessation screening and counseling

- **Current reporting period: Jan – June 2019**
- **Due to [redacted] 8/15/19**
- **Reported semi-annually**
- **All PCP, MH & SUD practices**
- **Medicaid denominator provided by partners**

4. ASSESS SCREEN 3: Use of Selected USPSTF Services for behavioral health population
   - 03.A: Intimate partner violence screening
   - 03.B: Blood pressure screening
   - 03.C: Adult Lipid disorder screening
   - 03.D: Adolescent Tobacco use interventions
   - 03.E: Adult Obesity screening and counseling
   - 03.E: Child Obesity screening and counseling
5. CARE.03_Sub_A: Hypertension -- Controlling high blood pressure
6. CARE.03_Sub_C : Comprehensive Diabetes Care -- HbA1C testing

- ***Current reporting period: CY 2018***
- ***Was Due to [redacted] 06/15/19***
- **Reported annually**
- **All PCP practices**
- **Medicaid BH sub-population (denominator) provided by DHHS**

7. HOSP INP 02: Timely transmission of transition record after Hospital Discharge

- ***Current reporting period: CY 2018***
- ***Was Due to [redacted] 06/15/19***
- **Reported annually**
- **All Hospitals**
- **Medicaid BH sub-population (denominator) provided by DHHS**

Greater Nashua IDN

NH DSRIP

Current Outcome Measures Provider Reporting Status

Greater Nashua IDN

NH DSRIP

2018 Calendar Year Measures: ***Was Due 06/15/19***
Jan-Jun 2019 Six Month Measures: **Due 08/15/19**

Practice Name	2018 Jan - Dec Calendar Year Measures Initial Feed	2019 Jan – Jun 6 month Measures Monthly/Manual Feed
	Due 06/15/19	Due 08/15/19
Dartmouth Hitchcock Clinic – Nashua	✓	✓*
Foundation Medical Partners	✓	In Progress
Greater Nashua Mental Health Center	N/A	✓
InteGreat Health	✓	✓
Lamprey Nashua	✓	✓
St. Joseph Primary Care Network		
The Emmaus Institute	N/A	✓
The Youth Council	N/A	✓
Merrimack River Medical Services	N/A	
Partnership for Successful Living (Harbor Homes, Keystone Hall)		

NOTE:
*DH may be resubmitting all of their Jan-Jun 2019 6 month measures prior to the 08/15/19 deadline

6

Use of Comprehensive Core Standardized Assessment (CCSA) Process by IDN Primary Care and BH Providers (ASSESS_SCREEN.01) – 6 Month Measure

Greater Nashua IDN

FUTURE: 75% is final 2020 minimum goal for ASSESS_SCREEN.01
CURRENT: 37.5% is the target for reporting period Jan to Jun 2019
5.8% of Total Funding Allocation

NH DSRIP

Practice Name	2018 Jan-Jun			2018 Jul - Dec			As of 07/08/19: Due 08/15/19				
	Den.	Num.	%	Den.	Num.	%	Not Processed Yet	Den.	Num.	Did Not Qualify	%
Dartmouth Hitchcock Clinic – Nashua	2126	0	0%	3631	0	0%	9	2882	0	7956	0%
Foundation Medical Partners	6329	0	0%	3939	0	0%	0	2674	3	2671	0%
Greater Nashua Mental Health Center	1870	979	52%	1865	1303	70%	0	1996	1733	263	87%
InteGreat Health	0	0	0%	69	0	0%	0	71	2	68	3%
Lamprey Nashua	0	0	0%	834	0	0%	0	1081	0	1081	0%
St. Joseph Primary Care Network	0	0	0%	538	0	0%	0	0	0	0	0%
The Emmaus Institute	0	0	0%	7	4	57%	6	2	2	0	100%
The Youth Council	0	0	0%	9	1	11%	0	12	11	1	92%
Merrimack River Medical Services	0	0	0%	0	0	0%	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0%	0	0	0%	0	0	0	0	0%

NOTE
- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.

7

Positive Screening & Appropriate Follow Up for Depression or SUD (ASSESS_SCREEN.02.A/B) – 6 Month Measure

Greater Nashua IDN

FUTURE: 80% is final 2020 minimum goal for ASSESS_SCREEN.02
CURRENT: 40% is the target for reporting period Jan to Jun 2019
4.5% of Total Funding Allocation

NH DSRIP

Practice Name	As of 07/08/19: Due 08/15/19				
	Not Processed Yet	Den.	Num.	Did Not Qualify	%
Dartmouth Hitchcock Clinic – Nashua	0	271	20	238	7%
Foundation Medical Partners	0	0	0	0	0%
Greater Nashua Mental Health Center	0	382	382	0	100%
InteGreat Health	0	26	1	19	4%
Lamprey Nashua	0	182	40	81	22%
St. Joseph Primary Care Network	0	0	0	0	0%
The Emmaus Institute	6	2	2	0	100%
The Youth Council	0	88	88	0	100%
Merrimack River Medical Services	0	0	0	0	0
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0

Note: Depression/SUD statistics for 2019 measurement period only available as one metric until the reporting period closes (i.e. not broken out yet).

NOTE
- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.

8

Positive Screening & Counseling for Tobacco Use (ASSESS_SCREEN.04) – 6 Month Measure

FUTURE: 80% is final 2020 minimum goal for ASSESS_SCREEN.04

CURRENT: 40% is the target for reporting period Jan to Jun 2019

3.1% of Total Funding Allocation

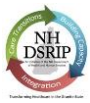
Practice Name	2018 Jan-Jun			2018 Jul - Dec			As of 07/08/19: Due 08/15/19				
	Den.	Num.	%	Den.	Num.	%	Not Processed Yet	Den.	Num.	Did Not Qualify	%
Dartmouth Hitchcock Clinic – Nashua	404	77	19%	320	55	17%	6	336	94	610	28%
Foundation Medical Partners	1490	1026	69%	718	481	67%	0	635	485	150	76%
Greater Nashua Mental Health Center	1469	0	0%	443	438	99%	0	367	343	24	93%
InteGreat Health	0	0	0%	46	1	2%	0	40	18	22	45%
Lamprey Nashua	0	0	0%	189	70	37%	0	233	110	123	47%
St. Joseph Primary Care Network	0	0	0%	5	4	80%	0	0	0	0	0%
The Emmaus Institute	0	0	0%	2	2	100%	6	2	2	0	100%
The Youth Council	0	0	0%	1	1	100%	0	0	0	0	0%
Merrimack River Medical Services	0	0	0%	0	0	0%	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0%	0	0	0%	0	0	0	0	0%

NOTE

- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.

9

Female Intimate Partner Violence Screening and Applicable Referrals (ASSESS_SCREEN.03.A)* – CY2018 Measure



CURRENT: No Gaps Allowed for reporting period Jan to Dec 2018

18% of Total Funding Allocation

Practice Name	As of 07/08/19: *Was Due 06/15/19*					
	Not Processed Yet	Den.	Num.	Did Not Qualify	Incomplete	%*
Dartmouth Hitchcock Clinic – Nashua	0	292	0	292	1	0%
Foundation Medical Partners	0	497	65	428	0	13%
InteGreat Health	0	8	0	8	0	0%
Lamprey Nashua	0	91	0	91	4	0%
St. Joseph Primary Care Network	0	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%

NOTE

- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.
- *Only applicable to Primary Care Provider (PCP) organizations as this measure requires an annual well-care visit
- ***Final reported % will be driven by IDN 3 BH sub-population supplied by DHHS**

10

Greater Nashua IDN

Adult Obesity Screening and Intervention (ASSESS_SCREEN.03.E)* – CY2018 Measure

NH DSRIP

CURRENT: No Gaps Allowed for reporting period Jan to Dec 2018
18% of Total Funding Allocation

Practice Name	As of 07/08/19: *Was Due 06/15/19*					
	Not Processed Yet	Den.	Num.	Did Not Qualify	Incomplete	%*
Dartmouth Hitchcock Clinic – Nashua	0	612	380	267	13	62%
Foundation Medical Partners	0	1031	572	459	0	55%
InteGreat Health	0	25	25	0	0	100%
Lamprey Nashua	0	234	211	23	0	90%
St. Joseph Primary Care Network	0	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%

NOTE
- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.
- *Only applicable to Primary Care Provider (PCP) organizations as this measure requires an annual well-care visit
- ***Final reported % will be driven by IDN 3 BH sub-population supplied by DHHS**

11

Greater Nashua IDN

Blood Pressure Screening: (ASSESS_SCREEN.03.B)* and Controlling High Blood Pressure (CARE.03_A)* – CY2018 Measure

NH DSRIP

CURRENT: No Gaps Allowed for reporting period Jan to Dec 2018
18% (ASSESS_SCREEN.03.B) and 19.7%(CARE.03_A) of Total Funding Allocation

Blood Pressure Screening: (ASSESS_SCREEN.03.B): 18% of Total Funding Allocation						
Practice Name	As of 07/08/19: *Was Due 06/15/19*					
	Not Processed Yet	Den.	Num.	Did Not Qualify	Incomplete	%*
Dartmouth Hitchcock Clinic – Nashua	0	1883	1861	22	55	99%
Foundation Medical Partners	0	3284	2115	1169	0	64%
InteGreat Health	0	71	71	0	0	100%
Lamprey Nashua	0	819	819	0	13	100%
St. Joseph Primary Care Network	0	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%
Controlling High Blood Pressure (CARE.03_A): 19.7% of Total Funding Allocation						
Dartmouth Hitchcock Clinic – Nashua	0	277	218	59	0	79%
Foundation Medical Partners	0	992	825	208	0	83%
InteGreat Health	0	1	1	0	0	100%
Lamprey Nashua	0	27	19	8	0	70%
St. Joseph Primary Care Network	0	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%

NOTE
- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.
- *Only applicable to Primary Care Provider (PCP) organizations as this measure requires an annual well-care visit
- ***Final reported % will be driven by IDN 3 BH sub-population supplied by DHHS**

12

Lipid Screening: (ASSESS_SCREEN.03.C)* and Comprehensive Diabetes Care (CARE.03.C)* – CY2018 Measure

Greater Nashua IDN

CURRENT: No Gaps Allowed for reporting period Jan to Dec 2018

18% (ASSESS_SCREEN.03.C) and 19.7%(CARE.03_C) of Total Funding Allocation

NH DSRIP

Practice Name	As of 07/08/19: *Was Due 06/15/19*					
	Not Processed Yet	Den.	Num.	Did Not Qualify	Incomplete	%*
Lipid screening: (ASSESS_SCREEN.03.C): 18% of Total Funding Allocation						
Dartmouth Hitchcock Clinic – Nashua	0	382	300	82	10	79%
Foundation Medical Partners	0	1250	623	627	15	50%
InteGreat Health	0	24	13	11	0	54%
Lamprey Nashua	0	306	138	168	3	45%
St. Joseph Primary Care Network	0	0	0	0		0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%
Comprehensive Diabetes Care (CARE.03.C): 19.7% of Total Funding Allocation						
Dartmouth Hitchcock Clinic – Nashua	0	0	0	0	0	0%
Foundation Medical Partners	0	418	269	227	0	64%
InteGreat Health	0	11	3	8	0	27%
Lamprey Nashua	0	36	16	25	0	44%
St. Joseph Primary Care Network	0	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%

NOTE
- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.
- *Only applicable to Primary Care Provider (PCP) organizations as this measure requires an annual well-care visit
- ***Final reported % will be driven by IDN 3 BH sub-population supplied by DHHS**

13

Child Tobacco Use Intervention or Prevention: (ASSESS_SCREEN.03.D)* and Child Obesity Screening and Intervention : (ASSESS_SCREEN.03.F)* – CY2018 Measure

Greater Nashua IDN

CURRENT: No Gaps Allowed for reporting period Jan to Dec 2018

18 % of Total Funding Allocation for Both

NH DSRIP

Practice Name	As of 07/08/19: *Was Due 06/15/19*					
	Not Processed Yet	Den.	Num.	Did Not Qualify	Incomplete	%*
Child Tobacco Use Intervention or Prevention: (ASSESS_SCREEN.03.D)						
Dartmouth Hitchcock Clinic – Nashua	0	687	0	639	0	0%
Foundation Medical Partners	0	496	3	493	0	1%
InteGreat Health	0	0	0	0	0	0%
Lamprey Nashua	0	195	165	30	27	85%
St. Joseph Primary Care Network	0	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%
Child Obesity Screening and Intervention : (ASSESS_SCREEN.03.F)						
Dartmouth Hitchcock Clinic – Nashua	0	643	447	196	0	70%
Foundation Medical Partners	0	1329	1016	298	0	76%
InteGreat Health	0	0	0	0	0	0%
Lamprey Nashua	0	506	485	20	2	96%
St. Joseph Primary Care Network	0	0	0	0	0	0%
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0	0	0	0%

NOTE
- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.
- *Only applicable to Primary Care Provider (PCP) organizations as this measure requires an annual well-care visit
- ***Final reported % will be driven by IDN 3 BH sub-population supplied by DHHS**

14

Greater Nashua IDN

Timely Transmission of Transitional Record After Hospital Discharge (HOSP_INP.02)* – CY2018 Measure

NH DSRIP

CURRENT: No Gaps Allowed for reporting period Jan to Dec 2018
18% of Total Funding Allocation

Practice Name	As of 07/08/19: *Was Due 06/15/19*					
	Not Processed Yet	Den.	Num.	Did Not Qualify	Incomplete	%*
Southern NH Medical Center	0	1730	1717	11	2	99%
St. Joseph Hospital	0	0	0	0	0	0%

NOTE

- The column designated as "Not Processed Yet" are those that [redacted] has received your data but has not yet run their analytics on thus are not represented as part of the numerator/denominator or "Did Not Qualify"
- "Did Not Qualify" represents events which were reported but did not qualify for that measure criteria.
- *Only applicable to Hospitals
- ***Final reported % will be driven by IDN 3 BH sub-population supplied by DHHS**

15

Event Notification (ENS) & Shared Care Plan (SCP) Usage Data

Greater Nashua IDN

NH DSRIP

Greater Nashua IDN

[redacted] ENS/SCP Partner Statistics
April 2019

NH DSRIP

Partner/Practice	Total # of Users	# of Active Users	# of Logins	Average Login Time per Active User (Hours)	# of Patients Being Monitored	# of Notifications Received	Total ED Visits (if hospital)	Total Active SCPs	# of SCPs Authored per Month	# of SCPs Updated per Month
Ascentria Care Alliance	0	0	0	0	0	0	0	0	0	0
Crotched Mountain	21	12	1	1.18	863	121	0	0	0	0
Department of Public Health - City of Nashua	0	0	0	0	0	0	0	0	0	0
Dartmouth Hitchcock Nashua	0	0	0	0	0	0	0	0	0	0
Foundation Medical Partners	0	0	0	0	0	0	0	0	0	0
Gateways Community Services	0	0	0	0	0	0	0	0	0	0
Granite State Independent Living (GSIL)	0	0	0	0	0	0	0	0	0	0
Greater Nashua Mental Health Center	6	1	1	3	2501	229	0	0	0	0
HEARTS Peer Support Center	0	0	0	0	0	0	0	0	0	0
Hillsborough County	0	0	0	0	0	0	0	0	0	0
Home Health and Hospice	0	0	0	0	0	0	0	0	0	0
LaMora Psychological Associates	0	0	0	0	0	0	0	0	0	0
Lamprey Health	2	0	0	0	19377	0	0	0	0	0
Life Coping	0	0	0	0	0	0	0	0	0	0
Merrimack River Medical Services	0	0	0	0	0	0	0	0	0	0
National Alliance for Mental Health (NAMI) NH	2	2	1	0.1		0	0	0	0	0
Harbor Homes	0	0	0	0	0	0	0	0	0	0
Keystone Hal	0	0	0	0	0	0	0	0	0	0
Healthy at Home	0	0	0	0	0	0	0	0	0	0
Revive Recovery Center	0	0	0	0	0	0	0	0	0	0
Southern NH Medical Center	0	0	0	0	0	270	3590	0	0	0
Southern NH Services	0	0	0	0	0	0	0	0	0	0
ST. Joseph Practices and Primary Care Network	0	0	0	0	0	0	0	0	0	0
ST. Joseph Hospital	0	0	0	0	0	0	0	0	0	0
YMCA	0	0	0	0	0	0	0	0	0	0
The Emmaus Institute	0	0	0	0	0	0	0	0	0	0
Youth Council	2	1	1	0.2	16	0	0	0	0	0

NOTE
- All information is based upon the patient profile each organization provided to [redacted] which may include all patients (not just Medicaid) for some.

17

Appendix

Greater Nashua IDN

NH DSRIP

Greater Nashua IDN

Positive Screening & Appropriate Follow Up for Depression (ASSESS_SCREEN.02.A)

NH DSRIP

FUTURE: 80% is final 2020 minimum goal for ASSESS_SCREEN.04

PAST: 30% was the target for reporting period Jul to Dec 2018

CURRENT: 40% is the target for reporting period Jan to Jun 2019

Practice Name	2018 Jan-Jun			2018 Jul - Dec			As of 05/23/19: Due 08/15/19				
	Den.	Num.	%	Den.	Num.	%	Not Processed Yet	Den.	Num.	Did Not Qualify	%
Dartmouth Hitchcock Clinic – Nashua	29	0	0%	241	6	2%	N/A	N/A	N/A	N/A	N/A
Foundation Medical Partners	891	474	53%	785	325	41%	N/A	N/A	N/A	N/A	N/A
Greater Nashua Mental Health Center	0	0	0%	242	242	100%	N/A	N/A	N/A	N/A	N/A
InteGreat Health	0	0	0%	18	15	83%	N/A	N/A	N/A		
Lamprey Nashua	0	0	0%	38	27	71%	N/A	N/A	N/A		
St. Joseph Primary Care Network	0	0	0%	5	4	80%	N/A	N/A	N/A		
The Emmaus Institute	0	0	0%	4	4	100%	N/A	N/A	N/		
The Youth Council	0	0	0%	4	4	100%	N/A	N/A	N/A		
Merrimack River Medical Services	0	0	0%	0	0	0%	N/A	N/A	N/A		
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0%	0	0	0%	N/A	N/A	N/A		

Note: Depression/SUD statistics for 2019 measurement period only available as one metric until the reporting period closes (i.e. not broken out yet).

19

Greater Nashua IDN

Positive Screening & Appropriate Follow Up for Substance Use Disorder (SUD) (ASSESS_SCREEN.02.B)

NH DSRIP

FUTURE: 80% is final 2020 minimum goal for ASSESS_SCREEN.04

PAST: 30% was the target for reporting period Jul to Dec 2018

CURRENT: 40% is the target for reporting period Jan to Jun 2019

Practice Name	2018 Jan-Jun			2018 Jul - Dec			As of 05/23/19: Due 08/15/19				
	Den.	Num.	%	Den.	Num.	%	Not Processed Yet	Den.	Num.	Did Not Qualify	%
Dartmouth Hitchcock Clinic – Nashua	5	0	0%	25	0	0%	N/A	N/A	N/A	N/A	N/A
Foundation Medical Partners	7	0	0%	3	0	0%	N/A	N/A	N/A	N/A	N/A
Greater Nashua Mental Health Center	0	0	0%	198	198	100%	N/A	N/A	N/A	N/A	N/A
InteGreat Health	0	0	0%	33	0	0%	N/A	N/A	N/A	N/A	N/A
Lamprey Nashua	0	0	0%	109	3	3%	N/A	N/A	N/		N/A
St. Joseph Primary Care Network	0	0	0%	0	0	0%	N/A	N/A	N/		
The Emmaus Institute	0	0	0%	2	2	100%	N/A	N/A			
The Youth Council	0	0	0%	4	4	100%	N/A	N/A			
Merrimack River Medical Services	0	0	0%	0	0	0%	N/A	N/A			
Partnership for Successful Living (Harbor Homes, Keystone Hall)	0	0	0%	0	0	0%	N/A	N/A	N		

Note: Depression/SUD statistics for 2019 measurement period only available as one metric until the reporting period closes (i.e. not broken out yet).

20

A1 Behavioral Health Capacity Building Development

Attachment A1.3a IDN Level Workforce Capacity Development Implementation Plan

Status	Task Name	Comments
Completed	I. Form Statewide Behavioral Health Workforce Capacity Taskforce (August - September 2016)	
Completed	A. IDN participation in monthly statewide all-IDN member meetings	
Completed	II. Develop inventory of existing workforce data, initiatives and activities; create gap analysis (September - October 2016)	
Complete	A. Develop statewide inventory of relevant in-process, completed, or proposed future workforce initiatives and data sets	
Complete	B. Develop planning framework that is both qualitative and quantitative with baseline assessment of current state of behavioral health workforce	
Complete	C. Identify gaps between available data sets, current workforce initiatives/activities and the information needed to enhance SUD and mental health workforce capacity regionally and statewide, including identification of areas where there are no current adequate data sets.	
Complete	III. Develop Statewide Behavioral Health Workforce Capacity Strategy Plan (October 2016 - January 2017)	
Complete	A. Identify workforce capacity requirements to meet demonstration goals	
Complete	A1. IDN conducts gap analysis process with member entity partners	
Complete	B. Develop statewide strategic plan to enhance workforce capacity across the spectrum of SUD and mental health providers in order to meet the identified requirements	
Complete	B1. Strategies are identified for utilizing and connecting existing SUD and BH resources	
Complete	B2. Strategies are identified to address gaps in education preparation of SUD and BH providers to ensure workforce readiness upon graduation	
Complete	B3. Strategies are identified to support training of non-clinical IDN staff in Mental Health First Aid	
Complete	B4. Strategies are identified to strengthen the workforce in specific areas of expertise such as Master Licensed Alcohol and Drug Counselors (MLADCs), licensed mental health professionals, Peer Recovery Coaches and other front line providers	
Complete	C. Finalize and submit plan to DHHS	
Complete	D. DHHS approves plan	
Complete	IV. Development, submission, and approval of IDN Workforce Capacity Development Implementation Plan (January - March 2017)	
Complete	A. Solicit requests for proposals from IDN member entity partners for strategies to address workforce recruitment, hiring, training and retention	
Complete	A1. Convene Behavioral Health Workforce Capacity Development and Retention Work Team	
Complete	A2. Develop RFP and process for review/decision-making	
Complete	A3. Release RFP and collect IDN member proposals	
Complete	A4. Work Team makes recommendations for strategies and funding allocations to Clinical Committee	
Complete	B. Clinical Committee reviews, approves and makes recommendations Finance Committee	
Complete	C. Finance Committee reviews and sets caps for specific funding caps (e.g., caps sign-on bonuses, relocation expenses, etc. and requirements for employee tenure)Submit budget for review and approval by Finance Committee	
Complete	C1. Finance Committee approves and makes recommendations to Executive Committee for approval	
Complete	D. Executive Committee approval budget and implementation plan strategies	
Complete	E. Submission of plan and budget to DHHS	
Complete	F. DHHS approval of budget and plan	
In progress	V. Implement IDN Workforce Capacity Development Plan with ongoing semi-annual reporting against targets identified in IDN and Statewide plan (March 2017 - December 2018)	
In progress	A. Actively participate in Statewide Workforce Task Force and individual WFTF Work Teams	
In progress	A1. IDN 3 is chair of the recruitment and hiring work team and convenes team regularly	
In progress	A2. IDN 3 is a member of the education and training work team participates in regular meetings	
In progress	A3. IDN 3 is a member of the policy work team and participates in regular meetings	
Complete	B. Conduct activities that increase knowledge of workforce hiring opportunities in the IDN region with its member entities	
Complete	B1. IDN conducts a Career Fair with national reach for potential new workforce members	
In progress	C. Support efforts that enhance internal HR capacity and/or expand outreach efforts for IDN member organizations to fill gaps in workforce to support IDN goals	
In progress	C1. Allocate funding for IDN member entities to support dues or fees for recruitment sites, services and social/print media campaigns	Recruiting fee max cap per position = $30,000 per IDN Finance Committee

In progress	C2. Allocate funding to support increased HR staffing capacity to develop job descriptions, and interview/onboard workforce members	
In progress	D. Support efforts to enhance potential applicants' interest in available workforce positions	
In progress	D1. Allocate funding for IDN member entities to provide sign-on bonuses	Caps:$10,000 for MD/Psychiatrist; $5,000 APRN/PA; $2,500 Psychiatric Certified Nurse; $1,000 all other IDN positions per IDN Finance Committee
In progress	D2. Allocate funding for IDN member entities to provide referral bonuses to incentivize existing staff to refer potential new workforce members	Cap: $500 per referral
In progress	D3. Allocate funding for IDN member entities to support relocation expenses	Caps: $8,000 for MD/Psychiatrist/Psychiatric APRN/PA; $2,500 for any other IDN position per IDN Finance Committee
In progress	E. Support efforts that retain and sustain existing and newly on-boarded members of the workforce	
In progress	E1. Allocate funding to increase satisfaction of existing BH staff through supporting professional development and/or CMEs/CEUs	Could entail professional dues for state associations, national professional associations, or medical licensure fees.
In progress	E2. Allocate funding to increase satisfaction of existing BH staff through supporting license fees or professional dues	Cap CME budget per Psychiatrist, APRN, PA and/or Psychiatric Certified Nurse: $2,500 every 2 years; $1,000 every two years all other staff per Finance Committee
In progress	E3. Allocate funding to increase satisfaction of existing BH staff through stay incentives or retention bonuses	Cap: $5,000/year Psychiatrists/MDs; $2,500/year all other IDN positions per IDN Finance Committee
In progress	E4. Allocate funding to increase satisfaction of existing BH staff through loan repayment assistance after certain time commitment to employer is met	Reimbursement for certification/training/education provided to employee after certain time commitment to employer is met.
In progress	E5. Allocate funding to increase satisfaction of existing BH staff through staff recognition	
In progress	F. Support efforts to recruit new workforce and/or expand capacity in existing workforce through internships/preceptor opportunities and supporting supervision through funding allocations	
In progress	F1. Allocate funding to support increasing the BH workforce through providing support for internships and preceptor opportunities, including intern stipends	
In progress	F2. Allocate funding to support increasing the number of MLADCs who can provide substance use treatment in the IDN by providing allocations to offset additional supervision/non-productive clinician time	Supports licensed supervisors (MLADCs, LMHCs, etc.) to provide supervision requirements for staff wanting to move to higher degree/licensure at $5,000 per supervisee per year (regardless of LADC/LMHC, etc) per IDN Finance Committee
In progress	G. Support efforts to train new and existing workforce in understanding issues associated with the goals of the IDN	
In progress	G1. Allocate funding to support training/technical assistance for Critical Time Intervention (CTI) team to implement strategies for care transitions, including intensive case management with clients diagnosed with SMI as they transition from IDN emergency departments and NH Hospital back to the community	
In progress	G2. Allocate funding to support training/technical assistance for Integrated Dual Diagnosis Treatment (IDDT) team for treating clients with co-occurring disorders	
In progress	G3. Allocate funding to support training for the multi-disciplinary core team (MDCT) members to build awareness, knowledge and skills to support goals of IDN	
In progress	G4. Support training for general IDN/community members	
In progress	G5. Conduct Annual Behavioral Health Conferences, open to the broader community, including professionals and stakeholders	
In progress	H. Support other integrated health Multi-Disciplinary Core Team (MDCT) support services	
Complete	A. Recruit and hire IDN/DSRIP Project Manager to support IDN goals and strategies	
Complete	B. Recruit and hire IDN/DSRIP Quality Manager to support IDN goals and strategies	
Complete	C. Support implementation of a Student Assistance Program in the Nashua Middle Schools	
Complete	D. Support implementation of a system of care wraparound model for families with children diagnosed with serious emotional disturbances	
In progress	E. Support clinical expertise for monthly MDCT case management for patients with intellectual/developmental disabilities	
In progress	F. Support clinical expertise those patients who could benefit from spirituality/faith-based resources	
In progress	G. Support increased awareness of the diversity of cultures in the IDN through education and provision of a CHW to support refugees and immigrants engage with needed health services and supports	
Complete	H. Support additional workforce supports through partnering with Dartmouth Hitchcock and their AmeriCorps VISTA grant for Community Resource Corps (Community Health Workers) for the IDN	

In progress	I. Identify potential opportunities to support closed loop screening and referral services	

A2 Health Information Technology (HIT) Infrastructure to Support Integration

attachment_A2.3a: IDN HIT/HIE Implementation Plan

attachment_A2.3a:
IDN HIT/HIE
Implementation Plan

Status	Task Name	Comments
Completed	Phase One: Statewide HIT Taskforce: Facilitated Current State Assessment (July - September 2016)	Achieved in prior reporting period
Completed	Phase Two: Statewide HIT Taskforce: Work Toward Consensus on Set of Minimally Required, Desired, and Optional HIT HIE Infrastructure Projects for IDNs to Pursue (October 2016 - March 2017)	Achieved in prior reporting period
Completed	III. Individual IDN Milestone: Develop Future State IDN-Specific Implementation Plans and Timelines (April - August 2017)	Achieved in prior reporting period
In Progress	IV. Operationalization of IDN HIT Implementation Plan	
In Progress	A. Data Extraction/Validation and Aggregation (Minimum Capability/Standard): Support IDN members in using a single vendor for reporting against the IDN-required metrics to DHHS	5 out of 8 provider entities are providing production data to [redacted] for Jan '19 to Jun '19 reporting period and will meet the [redacted] deadline of 08/15/19. 2 out of 2 member provider entities have entered data manually into [redacted] for Jan '19 to Jun '19 reporting period and will meet the [redacted] deadline of 08/15/19.
Completed	B. Internet Connectivity (Minimum Capability/Standard): Support IDN members to have secure connections to the Internet to engage in goals of IDN	Achieved in prior reporting period
In Progress	C. Secure Data Storage (Minimum Capability/Standard): Support IDN members to increase their ability and knowledge through providing access to technology and training to secure PHI	A total of 21 of 32 organizations have either certified EHRs who completed an assessment as part of their certification requirement or have completed the NIST/HIPAA assessment process and have submitted or are in the process of submitting attestation.
In Progress	D. Event Notification Service (ENS) and Transmit Event Notification (Minimum Capability/Standard): Support IDN members in their ability to produce and receive ADTs/notifications about patient's medical services encounters with authorized recipient who has an existing relationship to the patient	
In Progress	D1. Execute contracting materials between [redacted] and IDN for financial sponsorship and between [redacted] and IDN members for subscription/services	12 members have executed sub-contracting with [redacted]
In Progress	D2. Implement Transmit of Event Notification Service platforms for hospitals participating in pilot of [redacted]	Out of 2 hospitals, 1 has the ability to transmit ENS.
In Progress	D3. Implement Receiving of Event Notification Service platforms for ambulatory practices participating in pilot of PreManage	Out of 30 organizations, 6 have the ability to receive ENS, 8 are currently engaged in acquiring [redacted] for ENS, 2 do not qualify to access ENS and SCP.
In Progress	E. Shared Care Plan (Minimum Capability/Standard): Support IDN members' ability to access and/or contribute to an electronic shared care plan, which combines physical and behavioral health aspects to encourage a team approach to care for an individual patient, facilitating communication and the sharing of relevant care information among members of the care team (ideally including the patient).	Out of 30 organizations, 6 have the ability to access and/or contributed to SCP, 8 are currently engaged in acquiring [redacted] 2 do not qualify to access ENS and SCP.
In Progress	F. Direct Secure Messaging (Minimum Capability/Standard): Support IDN members in their ability to transmit patient information between providers using the protocol DSM, which establishes standards and documentation to support pushing data from where it is to where it's needed, supporting more robust interoperability in the future	Out of 32 entities, 21 have the ability to use DSM protocol.
In Progress	G. Discrete Electronic Data Capture (Desired Capability/Standard): Support applicable IDN member providers to capture discrete data and/or usage of a Certified Electronic Health Record Technology (CEHRT), as desired	Awaiting [redacted] functionality build or Statewide Closed Loop Referral Vendor decision for this solution
Completed	H. Integrated Secure Messaging (Desired Capability/Standard): Support applicable IDN members in their ability to use the protocol DSM to transmit patient information between providers, with integration in EHR system as a desire	Achieved in prior reporting period: Up to 6 partners have existing integrated direct secure messaging technology through their certified EHR systems.
Completed	I. Query-Based Exchange (Desired Capability/Standard): Support applicable IDN member providers to use Inter-Vendor capabilities to share, query and retrieve data to achieve IDN goals	Achieved in prior reporting period: Two IDN partners began the process of securing the ability to share, query, and retrieve data
In Progress	J. Closed Loop e-Referrals/Discrete Electronic Data Capture (Optional Capability/Standard): Support applicable IDN members in their ability to send referrals electronically in a closed loop system	Awaiting [redacted] functionality build or Statewide Closed Loop Referral Vendor decision for this solution
Completed	J1. Identify IDN member entities that might need platform	
In Progress	J2. Assign IT/Data Committee member to research platforms/vendors	An electronic CLR platform is being evaluated at a state level; some vendors being evaluated: Unite Us & Open Beds; the IDN 3 Data/IT Co-Chair has been involved in this evaluation process. The Data/IT Co-Chair presented his thoughts to the IDN 3 Data/IT Governance Committee The preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible.
In Progress	K. Secure Texting (Optional Capability/Standard): Support applicable IDN provider members in their ability to use secure texting for patient to agency, agency to agency, or other use cases, as desired	Achieved: 2 IDN partners are working with IDN to secure funding to achieve this functionality
Not Applicable	L. Data Analysis/Validation (Optional Capability/Standard): Support applicable IDN provider members in their ability to analyze data to generate non-required organizational or IDN-level reporting	
Completed	M. Population Health Tool (Optional Capability/Standard): Support applicable IDN member entities and/or provide capacity for the IDN Administrative Lead to identify high utilizers within populations at organizational or IDN level	Achieved in prior reporting period: SNHMC has been transmitting ENS for all ADT's and our providers now have the ability to monitor high ED utilizers based on default and custom triggers set in the [redacted] PreManage (ambulatory) platform. Out of this exercise, the IDN proposed creation of a sub-governance committee under the Data/IT Governance Committee called Collaborative Advisory Sub-Committee. This committee' would be a collaborative effort between Data/IT and Clinical with a focus on quality analysis to address gaps and identify what is working & what needs to be further address either via further reporting, clinical workflow re-evaluation or identified tools.
Completed	N. Capacity Management Tools (Desired Capability/Standard): Support applicable IDN member providers in their ability to see utilization and availability	Achieved in prior reporting period: The IDN has the ability to access [redacted] submissions for outcome measure analytics and is able to review and analyze provider utilization (and subsequently availability) through the use of available HIT platforms, including [redacted] PreManage platform and [redacted]
Not Started	O. Patient Engagement Technology (Optional Capability/Standard): Support appropriate IDN member providers to secure the ability to better engage patients, which includes telemedicine, secure texting and others	Patient engagement technology is not required by the IDN, therefore efforts to research options will be made at a later time.

B1 Integrated Health

attachment_B1.2a: IDN Integrated Healthcare Implementation Plan
attachment_B1.2b: Narrative Guidance
attachment_B1.8a: CCSA Domains Covered by IDN Primary Care and Behavioral Health Provider Practices/Organizations
attachment_B1.9c: IDN Member Entity Provider Use of Technology
attachment_B1.8ci: Multi-Disciplinary Team Training Schedule
attachment_B1.8hi: IDN-3 Guidelines & Protocols

attachment_B1.2a:
IDN Integrated Health
Implementation Plan

Status	Task Name	Comments
Completed	Stage 1: Project Planning and Progress Milestones (Development of Implementation Plan) January to June 2017	
Completed	Stage 1: Project Planning and Progress Milestones (Demonstrate Progress in Milestones along the SAMHSA Framework for Integrated Levels of Care) January to June 2017	
Completed	I. Identify/develop Comprehensive Core Standardized Assessment and screening tools applicable to adults, adolescents and children	
Completed	II. Identify/develop Shared Care Plan (SCP) for treatment and follow-up of both behavioral and physical health to appropriate medical, behavioral health, community, and social services	
Completed	A. Come to consensus on HIT vendor for SCP based upon recommendations of Statewide HIT Work Team	
Completed	B. Identification of clinical workflow between providers using SCP	
In Progress	B1. Identification of pilot users of SCP and level of access through [redacted] platform	
Completed	III. Identify/develop protocols for patient assessment, treatment, management	
Completed	IV. Identify/develop patient referral protocols including to those to/from PCPs, BH providers, social service support providers, hospitals and EDs	
Completed	V. Identify/develop core team meeting/communication plan and relevant workflows for communication among core care team and other patient providers, including case conferences	
Completed	VI. Identify/develop written roles and responsibilities for core team members and other members as needed	
Completed	A. IDN Clinical Governance Committee identifies/develops IDN recommended protocols and/or guidelines for core team member engagement	
In Progress	B. IDN members entities outline core team member roles and responsibilities and any other care team members (as applicable) through development of their Scope of Work (SOW) in the IDN sub-contract	
Completed	VII. Identify/develop training plan for each member of the core team and extended team as needed	
Completed	VIII. Identify/develop training curricula for each member of the core team and extended team as needed	
Completed	IX. Identify/develop agreements with participating providers and organizations, including referral protocols, formal arrangements (contract or MOU) with community-based social support service providers, coverage schedules, and consultant report turnaround time as appropriate	
In Progress	X. Identify/develop evaluation plan, including metrics to be used as ongoing impact indicators to provide a sense of whether or not the IDN is on the path to improve broader outcome measures that drive payment	
In Progress	A. Adoption of Coordinated Care Practice designation strategies by IDN primary care and behavioral health providers	
In Progress	B. Movement toward adoption of Integrated Care Practice designation strategies by IDN primary care and behavioral health providers	
In Progress	XI. Identify/develop mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to integration framework	
In Progress	A. IDN provider organizations create workflows and protocols for utilizing their EHRs to track and monitor individuals served by the project strategies	
In Progress	B. IDN primary care, behavioral health, and where applicable, social service support organizations utilize the IDN designated HIT vendor tools to track and monitor individuals served, adherence to project strategies, impact measures and fidelity to integration framework	
Completed	Stage 1: Project Utilization Milestones (Continued Progress Demonstrated for SAMHSA Integrated Levels of Care) July - December 2017	
Completed	I. Implementation of workforce plan	
Completed	II. Deployment of training plan	
In Progress	A. Train members of the multi-disciplinary core team (includes physical health providers, behavioral health providers and care managers/CHWs) across the IDN in core areas, including universal screening, co-occurring disorders, care planning/care coordination, understanding addiction, and cultural competency	
In Progress	A1. Provide training to up to 220 primary care providers, 84 behavioral health providers, and 132 care coordinators/case managers or Community Health Workers (CHWs) across IDN practices/organizations to increase understanding of universal screening and use of screening tools, including the social determinants of health	14 primary care; 9 behavioral health and 6 care coordinator/case managers were trained
In Progress	B. Train IDN provider organizations in issues related to co-occurring disorders, including management of chronic diseases including diabetes hyperglycemia, dyslipidemia, hypertension, and the nature of mental health disorders and substance use disorders	
In Progress	B1. Provide training to up to 220 primary care providers, 84 behavioral health providers, and 132 care coordinators/case managers or Community Health Workers (CHWs) across IDN practices/organizations to increase understanding of co-occurring disorders	7 primary care; 11 behavioral health; 7 care coordinators/case coordinators
In Progress	C. Train IDN provider organizations in care planning and care coordination, including motivational interviewing, HIPAA/secure data storage, the role of peer support integrated health, and others, as identified/requested by IDN Member Entities	
In Progress	C1. Provide training to up to 220 primary care providers, 84 behavioral health providers and up to 132 care coordinators/case managers or Community Health Workers across IDN practices/organizations in issues related to care planning and care coordination models and best practices to guide the treatment and management of the target sub-population.	7 primary care, 15 behavioral health and 12 care coordinators/case managers were trained
In Progress	D. Train IDN provider organizations in cultural competency and adaptation, including unpacking assumptions and stigma across cultures	
In Progress	D1. Provide training to up to 220 primary care providers, 84 behavioral health providers and up to 132 care coordinators/case managers or Community Health Workers across IDN practices/organizations in issues related to care planning and care coordination models and best practices to guide the treatment and management of the target sub-population.	41 primary care; 21 behavioral health and 32 care coordinators/case managers
In Progress	E. Train IDN provider organizations in issues related addiction to increase awareness and understanding of its effect and implications on their work	
In Progress	E1. Provide training to up to 220 primary care providers, 84 behavioral health providers, and 132 care coordinators/case managers or Community Health Workers (CHWs) across IDN practices/organizations to increase understanding of addiction	5 primary care; 21 behavioral health; and 20 care coordinators/case managers were trained
In Progress	F. Train non-direct care staff across the IDN provider practices/organizations to increase knowledge and awareness about personal beliefs related to mental health disorders to aid in their recognition and management in special situations and to better understand available codes for integrated care	
In Progress	F1. Provide training in mental health awareness to up to 262 non-direct care staff across IDN practices/organizations to increase understanding mental health disorders	
In Progress	F2. Provide training cultural competency and adaptation to up to 262 non-direct care staff across IDN practices/organizations	
In Progress	F3. Provide training in addressing challenges with coding to up to 262 non-direct care staff across IDN practices/organizations	
Not Started	G. Train case managers, behavioral health care coordinators/specialists in SAMHSA's integrated health core competencies through a cohort model to build a support team in the IDN	
Completed	III. Use of annual Comprehensive Core Standardized Assessment	
Completed	A. Engage leaders from each IDN provider organization to be an Advisory Committee to the IDN Admin Lead team to provide clinical guidance for process guidelines, including IDN CMO, as well as CEOs, CMOs, and clinical leaders	
Completed	B. Develop IDN 3 CCSA tool with CCSA and Referrals Work Team	
Completed	C. Identify IDN protocols and guidelines workflows for depression and SUD screening, including tool identification and use, protocols for positive screens and workflow/protocols for intervention/follow-up plan	
In Progress	D. Engage IDN provider practices/organizations in identifying next steps for operationalizing workflows for use of CCSA	
In Progress	D1. Identify key roles in each pilot practice/organization to support CCSA implementation	
Completed	D2. Identify platform for implementing CCSA in pilot practice for each IDN provider organization (paper and scanned, electronic input into tablet or built into EHR)	
In Progress	IV. Use of Shared Care Plan	
In Progress	A. Engage IDN members through development and work of SCP and Case Management Work Team to develop IDN policies and protocols for use of SCP	
Completed	B. Come to consensus on statewide guidelines for SCP sections across IDNs	

In Progress	C. Identification of clinical workflow between providers using SCP	
In Progress	C1. Identification of template SCP criteria based upon SCP Taskforce, tailored to IDN 3 needs/goals	
In Progress	C2. Identification of pilot use of SCP in IDN	
In Progress	C2. Work with SCP and Case Management Work Team to identify which population, strategy, and/or IDN Member Organizations will pilot use of SCP	through IDN protocols and guidelines
In Progress	D. Identification of process for incorporating patient screening and assessment results into patient goals in SCP	
Not Applicable	D1. Work with CCSA and Referrals Work Team and SCP and Case Management Work Team to determine workflow and protocols for working with patient to identify patient goals for inclusion in SCP	
In Progress	D2. Pilot workflows and protocols for incorporating CCSA positive screening results into patient goals for SCP	
In Progress	D2a. CTI team conducts a pilot of workflow for CTI patients completing CCSA with CTI Specialists incorporating follow-up plan/interventions from CCSA into SCP tool	expected by September 2018
In Progress	D2b. Pilot with IDDT patients and with broader B1 projects	expected by October 2018
In Progress	E. Identification of Care Guidelines from SCP to be incorporated into [redacted] ADT to emergency departments flags at SNHMC and St. Joseph Hospital	
In Progress	E3. Clinical Governance Committee votes on care guideline recommendations	expected by September 2018
In Progress	V. Operationalization of core team meeting/communication plan, including case conferences	
In Progress	A. Initiate multi-disciplinary core team structure/processes	
In Progress	A3. Initiate B1 multi-disciplinary core team structure processes with provider organizations	as part of SOW in IDN sub-contracts
In Progress	B. Initiate use of shared care planning workflows and protocols	
In Progress	VI. Use of EHR, electronic coordinated care management system, or other documented work flow to ensure timely communication of clinical and other information critical to diagnosis, treatment and management of care	
In Progress	A. Engage IDN member entities in piloting workflow protocols and tools for assessing, treating and managing IDN attributed patients	
In Progress	B. Engage [redacted] as IDN HIT vendor platform to assist in information sharing across IDN member providers, including event notification for patient admissions, discharges and transfers across IDN provider organizations	
Completed	B1. IDN Administrative Lead completes Sponsorship Agreement with [redacted] to support [redacted] and [redacted] on behalf of IDN providers	
In Progress	B2. Engage IDN hospitals in contracting with [redacted] and participating in meetings and calls with [redacted] project management staff to implement the [redacted] platform to receive and submit ADTs for the IDN attributed Medicaid population	
Completed	B2a. SNHMC	SNHMC went live with [redacted] Pre-Manage ED on 09/18/18
In Progress	B2b. St. Joseph Hospital and Physician Practices	
In Progress	C2c. Engage IDN provider organizations and practices in contracting with [redacted] and participating in meetings and calls with [redacted] project management staff to implement the [redacted] platform to increase information sharing through use of the Event Notification Service (ENS) and Shared Care Plan (SCP) for the IDN attributed Medicaid population	
In Progress	C3. Engage [redacted] as IDN HIT vendor platform to assist in information sharing across IDN member providers, including direct secure messaging (DSM) and closed loop referral implementation across IDN provider organizations	
Completed	Stage 1: Outcome Metrics (Initiation of Data Reporting) July to December 2017	
Completed	Stage 2: Outcome Metrics (Ongoing Data Reporting) January to June 2018	
	Stage 3: Outcome Metrics (System Transformation Utilization Milestones): Ongoing Data Reporting July - December 2018	
In Progress	A. Report on the number of Medicaid beneficiaries received Comprehensive Core Standardized Assessment (during reporting period and cumulative) vs. projected	
In Progress	B. Report on the number of Medicaid beneficiaries scoring positive on scoring tools	
In Progress	C. Report on the number of Medicaid beneficiaries scoring positive on scoring tools and referred for additional intervention	
In Progress	D. Report on the number of new staff recruited and trained (during reporting period and cumulative) vs. projected	
In Progress	E. Report on the new staff vacancy and turnover rate for period and cumulative vs. projected	
In Progress	F. Report on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-support program elements	

Partner Name/Site	Topic	Identified Progress	Barriers	Mitigation Plan
DARTMOUTH HITCHCOCK				
	Progress on CCSA implementation	*Has been implementing a partial CCSA process that includes questions about the social determinants of health (as part of its Substance Use and Mental Health Initiative--SUMHI), as well as universal screening on depression. Implementation of the system wide CCSA process will begin in August with the on-boarding of the IDN-funded Resource Specialist, who will support the existing IDN-funded BH Clinicians.	*Implementation of the full CCSA process, following IDN Guidelines has been stalled due to organization's need to fill the Resource Specialist role, who will support referral pathways for positive screens related to questions about social determinants of health.	*Hired CHW ("Resource Specialist") to start 7/28/19 with expectation of CCSA operationalization by 9/16/19
	Progress on MDCT including required trainings	*The DH MDCT meets weekly with a PCP (as applicable), BH Clinician (funded by the IDN), care coordinator (in August, this will be a newly on-boarded Resource Specialist, funded by the IDN), and Psychiatrist (as applicable); monthly behavioral health meetings also include practice managers and quality team members to identify opportunities and needs to support the integrated care team.		
	MDCT training attendance	•CCSA: PCP and Psychiatrist •Understanding Addiction: PCP •Cultural Competency: PCP •Care Planning/Coordination: none •Co-Occurring Disorders: PCP, Care Coordinator •MHFA: PCP		
	Progress on Closed Loop Referral	n/a	*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*IDN will highlight closed loop referral process and supporting tools at August or September Full IDN meeting for partners to learn from each other
	Progress on Secure Messaging	*DH has participated in the IDN "testing" of the organization's integrated DSM capability as part of their EHR to send and receive patient information from IDN providers and has provided list of organization/practice DSM IDs to IDN which will be published to all of our IDN partners		
	Progress on MDCT schedules	*weekly meetings on Tuesdays 11am-12pm		
	Progress on Workflow/Protocols for each of the following:	*Crosswalk for all workflows/protocols was in progress but key point of contact retired	*Key point of contact to IDN retired in June	*IDN Admin team working with alternate point of contact to engage in deliverables/expectations
	Interactions between providers and community based organizations	"	"	"
	Timely communications	"	"	"
	Coordination among case managers internal and external	"	"	"
	Safe transitions from institutional settings back to primary care, BH and social support service providers	"	"	"
	Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	"	"	"
	Adherence to NH Board of Medicine guidelines on opioid prescribing	"	"	"
	Progress on Additional Integrated Practice designation requirements:			
	Adoption of medication assisted treatment	*identified pilot program approach	*MAT not currently operational	*targeting September '19 go-live; identified pilot provider (Nashua Family Practice); toolkit/workflows under design; trainings scheduled for July/August; will begin with weekly meetings
	Adoption of evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	*in place		
	Use of technology to identify, at minimum:			
	At risk patients		[redacted] contracting completed at the system level, with next steps including assigning on-boarded Resource Specialist (in August) to be the "care navigator" to triage and share relevant information with applicable team members.	*Will need to work with system level leaders to identify IDN attributed Medicaid beneficiaries for Nashua practices to include in the patient file uploaded to [redacted] determining schedule for sending updated files.
	plan care		*not leveraging [redacted] shared care plan platform currently	*Will likely implement SCP as part of MDCT protocols/workflows once the Resource Specialist is on-boarded and trained in August.
	monitor/manage patient progress toward goals	*as part of EHR	*not leveraging [redacted] shared care plan platform currently	
	ensure closed loop referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*An electronic CLR platform is being evaluated at a state level; some vendors being evaluated: Unite Us & Open Beds; the IDN 3 Data/IT Co-Chair has been involved in this evaluation process; the Data/IT Co-Chair presented his thoughts to the IDN 3 Data/IT Governance Committee; the preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible
	Documented workflows with community based social support service provides including, at minimum:	*Crosswalk for all workflows/protocols was in progress but key point of contact retired	*Key point of contact to IDN retired in June	*IDN Admin team working with alternate point of contact to engage in deliverables/expectations
	Joint service protocols	"	"	"
	Communication channels	"	"	"
	Progress on use of HIT			
FOUNDATION				
	Progress on CCSA implementation	*using IDN3 CCSA which has been embedded as a template in their EHR *ECCs conducting CCSAs on patients in FMP's Complex Care Management program, which includes patients with other forms of insurance beyond Medicaid; 55 CCSAs have been completed to date with this population; see attached workflows/protocols.		

	Progress on MDCT including required trainings	*FMP is in the process of piloting an integrated care model with in 2 primary care practices in Nashua (Downtown Medical Associates and Internal Medicine of Nashua); this pilot is the beginning of the organization's roll-out of this model to acclimate medical and other direct care staff to the embedded model of integrated care; to date, there have been RN Embedded Care Coordinators (ECCs) in the majority of the practices (who are implementing the CCSA process), a psychiatrist and 2 psychiatric nurse practitioners who have been supporting the practices with BH medication management and providing consultation, as well as 2 medical home social workers (adult and pediatric) and embedded mental health clinicians in 4 practices; for those practices where there are not embedded mental health therapists, providers have been referring to Foundation Community Care, which provides longer term BH services with therapists, an APRN, and a psychiatrist; weekly huddles already occur in those 2 primary care practices, including a PCP, ECC, and a mental health clinician, as well as psychiatrist consultation when needed.	*This pilot has been stalled a bit due to FMP gearing up to open its MAT clinic in July	*Once MAT clinic is up and running, this pilot will resume
	MDCT training attendance	•CCSA: Care Coordinator •Understanding Addiction: none •Cultural Competency: none •Care Planning/Coordination: Care Coordinator •Co-Occurring Disorders: none •MHFA: Care Coordinator		
	Progress on Closed Loop Referral	*Awaiting attestation response to current policy/protocols/workflows for closed loop referral to determine level of closed loop particularly in FMP's Complex Care Management program	*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*IDN will highlight closed loop referral process and supporting tools at August or September Full IDN meeting for partners to learn from each other
	Progress on Secure Messaging	*FMP has an IDN-sponsored contract with [redacted] and has also participated in the IDN "testing" of the organization's integrated DSM capability to send and receive patient information from IDN providers and has provided list of organization/practice DSM IDs to IDN which will be published to all of our IDN partners		
	Progress on MDCT schedules	*In progress, with monthly case management meeting to be up and running by Fall 2019 once the MAT clinic is operational.		
	Progress on Workflow/Protocols for each of the following:			
	Interactions between providers and community based organizations	see attached		
	Timely communications	*awaiting attestation		
	Coordination among case managers internal and external	*awaiting attestation		
	Safe transitions from institutional settings back to primary care, BH and social support service providers	see attached		
	Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	see attached		
	Adherence to NH Board of Medicine guidelines on opioid prescribing	*in place; see attached		
	Progress on Additional Integrated Practice designation requirements:			
	Adoption of medication assisted treatment	*Slated to start at the end of July 2019 in clinic setting at West Campus (in previous FMP Internal Medicine suite); referrals to initially come from BHU (in-patient, IOP, PHP), SNHMC emergency department and from the practices. Year 1 will have up to 30 "cases" (aka "active prescriptions"), with year 2 having up to 150 cases and year 3 (and beyond) maxing out at 250 cases; likely will have up to 6 prescribers who were recently waivered, with an MLADC, care coordinator and patient service rep/medical assistant serving as the care team		
	Adoption of evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	*not currently in use for FMP		
	Use of technology to identify, at minimum:			
	At risk patients	*use of registry/care management platform within EHR for Complex Care Management (CCM) program, which systematically identifies transitioning and at-risk patients, engaging them in transparent care coordination/management with the ECCs		
	plan care	*there are several existing workgroups who are utilizing the information gleaned from the care management platform, including the Care Transitions Steering Committee, Congestive Heart Failure (CHF) and COPD work groups, and the Avoidable ED Visits/Ambulatory Sensitive Inpatient Admissions work group		
	monitor/manage patient progress toward goals	*use of registry/care management platform within EHR for Complex Care Management (CCM) program, which systematically tracks work with patient to meet identified goals		
	ensure closed loop referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*An electronic CLR platform is being evaluated at a state level; some vendors being evaluated: Unite Us & Open Beds; the IDN 3 Data/IT Co-Chair has been involved in this evaluation process; the Data/IT Co-Chair presented his thoughts to the IDN 3 Data/IT Governance Committee; the preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible
	Documented workflows with community based social support service provides including, at minimum:	*awaiting attestation		
	Joint service protocols	"		
	Communication channels	"		

	Progress on use of HIT	*FMP has met all of the reporting milestones and are now actively reviewing their data being sent to [redacted] to determine any corrective actions; they have started meeting on a regular basis which includes representatives from: Report Writing Team, Management, Clinical, Quality; they have identified areas where they are addressing updating workflows/internal policies/updating EHR templates *FMP is in the process of acquiring [redacted] for ENS to monitor all of their Medicaid patients through the portal & plan to assign Care Coordinators to the patients in FMP's Complex Care Management program *FMP has acquired [redacted] & completed Integrated DSM testing with the IDN is expected to continue to use this capability as a communication method for transfer of PHI between IDN partners; they have provided their practice & the SNHMC DSM ID's to the IDN for publication for all IDN partners.	*Use of SCP not being considered at this time	*Continue conversation about ways to address confidentiality concerns with use of [redacted]
GREATER NASHUA MENTAL HEALTH				
	Progress on CCSA implementation	*GNMH implemented the CCSA process (using their existing ANSA tool, which was approved by the IDN Clinical Governance Committee) in 2018; ~1700 have been completed to date.	*Sharing the information learned from the CCSA process with primary care partners is a barrier.	*Currently, GNMH is piloting this process through its IDN-funded InteGreat Health pilot with Lamprey Health Care; the InteGreat Health Case Manager and Project Manager have been working with the clinical and IT operations team to identify how to easily share what is learned with the Lamprey Health primary care provider for use in the client's individualized care plan as well as in the weekly huddles and monthly MDCT case conferences.
	Progress on MDCT including required trainings			*will be part of IDN 3 regional MDCT and some are part of InteGreat Health MDCT
	MDCT training attendance	•CCSA: BH Clinician (CTI, IDDT, InteGreat Health); Care Coordinator/Case Manager (IDDT and InteGreat Health); Psychiatrist (InteGreat Health and IDDT) •Understanding Addiction: PCP (InteGreat Health); BH (IDDT); Care Coordinator/Case Manager (CTI and IDDT); Psychiatrist (InteGreat Health and IDDT) •Cultural Competency: BH Clinician (CTI and IDDT); Care Coordinator/Case Manager (IDDT and InteGreat Health) •Care Planning/Coordination: PCP (InteGreat Health); BH Clinician (CTI, IDDT and InteGreat Health); Care Coordinator/Case Manager (CTI, IDDT, InteGreat Health); Psychiatrist (IDDT) •Co-Occurring Disorders: PCP (InteGreat Health); BH Clinician (CTI, IDDT and InteGreat Health); Psychiatrist (InteGreat Health) •MHFA: Care Coordinator/Case Manager (CTI, IDDT and InteGreat Health)		*will be part of IDN 3 regional MDCT and some are part of InteGreat Health MDCT
	Progress on Closed Loop Referral	*in process of being developed		*In process of implementing a PCP Communication Form which will ensure closed loop and monitoring for any referring PCPs. With other referring entities, our intake procedure includes confirming the intake occurred and outcome (became pt or referred out); other information provided if client provides consent.
	Progress on Secure Messaging	*GNMHC has an IDN-sponsored contract with [redacted] and has also participated in the IDN "testing" of [redacted]	*Need to know if their internal process uses the organization's integrated DSM capability to send and receive patient information from IDN providers; they have funding for this capability- this capability has not been tested yet.	*Awaiting clarity as to next steps.
	Progress on MDCT schedules	*only for InteGreat (see Lamprey below)		*will be part of IDN 3 regional MDCT and some are part of InteGreat Health MDCT
	Progress on Workflow/Protocols for each of the following:	*awaiting attestation		
	Interactions between providers and community based organizations	*attestation received except for SCP (yes within the InteGreat program with Lamprey)	*As a CMHC are held to expectations/requirements as indicated in the HeMs and Federal regulations' as mentioned, can mitigate by managing consent at the organizational level	*Partnering with Lamprey and are willing to partner with other healthcare providers with the appropriate organization level releases in place; continue conversation about ways to address confidentiality concerns with use of [redacted] for SCP; ilf unable to resolve, work with other high volume partners in addition to Lamprey (e.g., SNNHS) to develop alternative method; depends upon timing of confidentiality concerns being sufficiently addressed; open to alternative approaches if they can be vetted for confidentiality concerns
	Timely communications	*Yes to [redacted] and [redacted] No to SCP	*If SCP through [redacted] is considered a required part of timely communication the answer is no.	*Continue conversation about ways to address confidentiality concerns with use of [redacted] are about to implement a formal "PCP Communication Form" this will trigger on admit, yearly, and at times of significant change; it is a form that provides updated information to all clients' PCPs; will be implemented prior to 9/30/19
	Coordination among case managers internal and external	*attestation received		
	Safe transitions from institutional settings back to primary care, BH and social support service providers	*attestation received		
	Intake procedures that include systematically soliciting patient consent to confidentially share information among providers		*Current intake procedures include establishing patient consent for sharing information with all entities a client is currently engaging with; Senior Leadership Team will be reviewing a potential notice to Medicaid pts within the month of July	*QI Director will create an implementation plan to ensure notice to patients incorporated into intake procedures by 9/30/19
	Adherence to NH Board of Medicine guidelines on opioid prescribing	*attestation received		
	Progress on Additional Integrated Practice designation requirements:	complete		
	Adoption of medication assisted treatment	*attestation received		
	Adoption of evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	*attestation received		
	Use of technology to identify, at minimum:			
	At risk patients	*unknown		
	plan care		*not leveraging [redacted] shared care plan platform currently	
	monitor/manage patient progress toward goals	*as part of EHR	*not leveraging [redacted] shared care plan platform currently	

	ensure closed loop referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*An electronic CLR platform is being evaluated at a state level; some vendors being evaluated: Unite Us & Open Beds; the IDN 3 Data/IT Co-Chair has been involved in this evaluation process; the Data/IT Co-Chair presented his thoughts to the IDN 3 Data/IT Governance Committee; the preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible
	Documented workflows with community based social support service provides including, at minimum:	*complete		
	Joint service protocols	*attestation received		
	Communication channels	*attestation received		
	Progress on use of HIT	-GNMHC has met all of the [redacted] reporting milestones and are on a monthly export cadence to [redacted] -GNMHC has [redacted] for ENS to monitor all of their Medicaid patients through the portal -GNMHC has acquired [redacted] They have completed [redacted] DSM testing & provided their [redacted] DSM ID to the IDN for publication for all IDN partners.	-For outcome measure reporting, do not currently have insight into their on-going quality inspection process -Need to complete Integrated DSM testing with the IDN	
LAMPREY				
	Progress on CCSA implementation	n/a	unable to implement CCSA due to time required to complete/review, physical space to support, and lack of resources to execute	have developed a plan to implement starting with their prenatal population during their intake process; awaiting reformatting of their file template in order to implement
	Progress on MDCT including required trainings	Implemented weekly huddles as well as monthly case management meetings		
	MDCT training attendance	•CCSA: Care Coordinator/Case Manager (InteGreat Health and Lamprey Health); Psychiatrist (InteGreat Health and IDDT) •Understanding Addiction: PCP (InteGreat Health and Lamprey Health) •Cultural Competency: Care Coordinator/Case Manager (InteGreat Health and Lamprey Health); Psychiatrist (InteGreat Health and Lamprey Health) •Care Planning/Coordination: PCP (InteGreat Health); BH Clinician (InteGreat Health and Lamprey Health); Care Coordinator/Case Manager (InteGreat Health and Lamprey Health) •Co-Occurring Disorders: PCP (InteGreat Health); BH Clinician (InteGreat Health and Lamprey Health); Care Coordinator/Case Manager (InteGreat Health and Lamprey Health); Psychiatrist (InteGreat Health and Lamprey Health) •MHFA: Care Coordinator/Case Manager (InteGreat Health)		
	Progress on Closed Loop Referral	*attestation received	*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*IDN will highlight closed loop referral process and supporting tools at August or September Full IDN meeting for partners to learn from each other
	Progress on Secure Messaging	Lamprey/InteGreat has an IDN-sponsored contract with [redacted] and has also participated in both [redacted] & Integrated DSM "testing" with the IDN; they are working through their process to determine in what capacity each will be used - one may be used for in-bound messages and the other for out-bound.	*workflow attestation needed	
	Progress on MDCT schedules	*Lamprey meets 1st Monday/month 12:30-1:30 (*InteGreat meets weekly Monday 5-5:30 and Wednesday 12:30-1)		
	Progress on Workflow/Protocols for each of the following:	complete		
	Interactions between providers and community based organizations	*attestation received		
	Timely communications	*attestation received		
	Coordination among case managers internal and external	*attestation received		
	Safe transitions from institutional settings back to primary care, BH and social support service providers	*attestation received		
	Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	*attestation received		
	Adherence to NH Board of Medicine guidelines on opioid prescribing	*attestation received		
	Progress on Additional Integrated Practice designation requirements:	complete		
	Adoption of medication assisted treatment	*attestation received		
	Adoption of evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model	*attestation received		
	Use of technology to identify, at minimum:			
	At risk patients	*unknown		
	plan care		*not leveraging [redacted] shared care plan platform currently	
	monitor/manage patient progress toward goals	*as part of EHR	*not leveraging [redacted] shared care plan platform currently	
	ensure closed loop referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*An electronic CLR platform is being evaluated at a state level; some vendors being evaluated: Unite Us & Open Beds; the IDN 3 Data/IT Co-Chair has been involved in this evaluation process; the Data/IT Co-Chair presented his thoughts to the IDN 3 Data/IT Governance Committee; the preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible
	Documented workflows with community based social support service provides including, at minimum:	complete		
	Joint service protocols	*attestation received		
	Communication channels	*attestation received		

	Progress on use of HIT	-Lamprey has met all of the [redacted] reporting milestones and are on a monthly export cadence to [redacted] -Lamprey has [redacted] for ENS to monitor all of their Medicaid patients through the portal & has established Medicaid specific cohorts & reporting -Lamprey/InteGreat has an IDN-sponsored contract with [redacted] and has also participated in both [redacted] & Integrated DSM "testing" with the IDN; they are working through their process to determine in what capacity each will be used - one may be used for in-bound messages and the other for out-bound.	*workflow attestation needed for their process to determine in what capacity each DSM capability will be used	
SOUTHERN NH MEDICAL CENTER				
	Progress on CCSA implementation	n/a		
	Progress on MDCT including required trainings	n/a		
	MDCT training attendance	n/a		
	Progress on Closed Loop Referral	n/a		
	Progress on Secure Messaging	SNHMC has participated in the IDN "testing" of the organization's integrated DSM capability to send and receive patient information from IDN providers and has provided list of organization/practice DSM IDs to IDN which will be published to all of our IDN partners		
	Progress on MDCT schedules	n/a		
	Progress on Workflow/Protocols for each of the following:			
	Interactions between providers and community based organizations			
	Timely communications	HOSP_INP.02 measure reporting?		
	Coordination among case managers internal and external			
	Safe transitions from institutional settings back to primary care, BH and social support service providers			
	Intake procedures that include systematically soliciting patient consent to confidentially share information among providers			
	Adherence to NH Board of Medicine guidelines on opioid prescribing			
	Progress on Additional Integrated Practice designation requirements:			
	Adoption of medication assisted treatment			
	Adoption of evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model			
	Use of technology to identify, at minimum:			
	At risk patients			
	plan care			
	monitor/manage patient progress toward goals			
	ensure closed loop referral			
	Documented workflows with community based social support service provides including, at minimum:			
	Joint service protocols			
	Communication channels			
	Progress on use of HIT	-SNHMC has reported the 1 measure (HOSP_INP.02) they are required to report to [redacted] [redacted] SHHMC has been transmitting ENS via [redacted] since 09/2018 -SNHMC has completed Integrated DSM testing with the IDN		
THE EMMAUS INSTITUTE				
	Progress on CCSA implementation	Has been completing the CCSA process since 2018, with 8 clients completing the process.		
	Progress on MDCT including required trainings	Has participated in case management meetings with the GNMH's CTI team	Sharing of operational MDCTs has not been provided to BH providers to allow for access to engaging in case management meetings for those IDN Medicaid beneficiaries with complex health care needs.	*will be part of IDN 3 regional MDCT
	MDCT training attendance	•CCSA: BH Clinician •Understanding Addiction: BH Clinician •Cultural Competency: BH Clinician •Care Planning/Coordination: BH Clinician •Co-Occurring Disorders: BH Clinician •MHFA: none		*will be part of IDN 3 regional MDCT
	Progress on Closed Loop Referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*IDN will highlight closed loop referral process and supporting tools at August or September Full IDN meeting for partners to learn from each other
	Progress on Secure Messaging	*has DSM capabilities through [redacted]		
	Progress on MDCT schedules		Sharing of operational MDCTs has not been provided to BH providers to allow for access to engaging in case management meetings for those IDN Medicaid beneficiaries with complex health care needs.	By early Fall 2019, the IDN will be sharing the dates and contacts for the MDCT monthly case management meetings being operationalized to enable access for all BH providers, as applicable.
	Progress on Workflow/Protocols for each of the following:	*awaiting attestation	*resource constraints	*once IDN Admin team clinical consultant is on board, provide support to partner for completion of crosswalk
	Interactions between providers and community based organizations	"	"	"
	Timely communications	"	"	"
	Coordination among case managers internal and external	"	"	"
	Safe transitions from institutional settings back to primary care, BH and social support service providers	"	"	"
	Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	"	"	"
	Adherence to NH Board of Medicine guidelines on opioid prescribing	n/a		
	Progress on Additional Integrated Practice designation requirements:			
	Adoption of medication assisted treatment	n/a		
	Adoption of evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model			
	Use of technology to identify, at minimum:			
	At risk patients	*unknown		

	plan care		*not leveraging [redacted] shared care plan platform currently	
	monitor/manage patient progress toward goals	*manually through progress notes	*not leveraging [redacted] shared care plan platform currently	
	ensure closed loop referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*An electronic CLR platform is being evaluated at a state level; some vendors being evaluated: Unite Us & Open Beds; the IDN 3 Data/IT Co-Chair has been involved in this evaluation process; the Data/IT Co-Chair presented his thoughts to the IDN 3 Data/IT Governance Committee; the preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible
	Documented workflows with community based social support service provides including, at minimum:	*awaiting attestation	*resource constraints	*once IDN Admin team clinical consultant is on board, provide support to partner for completion of crosswalk
	Joint service protocols	"	"	"
	Communication channels	"	"	"
	Progress on use of HIT	-Emmaus is manually reporting to [redacted] on a regular basis for Assess.01, 02 04; they are not required to report on any of the CY2018 measures. -Emmaus will have [redacted] shortly - patient file generation & upload in progress -Emmaus has DSM capabilities through IDN [redacted] sponshorship		
THE YOUTH COUNCIL				
	Progress on CCSA implementation	*conducting CCSA's for all Medicaid patients using the IDN CCSA paper tool since 12/2018; completed 11 CCSAs in Jan-Jun reporting period		
	Progress on MDCT including required trainings		*Sharing of operational MDCTs has not been provided to BH providers to allow for access to engaging in case management meetings for those IDN Medicaid beneficiaries with complex health care needs.	*will be part of IDN 3 regional MDCT
	MDCT training attendance	•CCSA: BH Clinician •Understanding Addiction: BH Clinician •Cultural Competency: BH Clinician •Care Planning/Coordination: BH Clinician •Co-Occurring Disorders: BH Clinician •MHFA: none		*will be part of IDN 3 regional MDCT
	Progress on Closed Loop Referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*IDN will highlight closed loop referral process and supporting tools at August or September Full IDN meeting for partners to learn from each other
	Progress on Secure Messaging	-has DSM capabilities through [redacted]		
	Progress on MDCT schedules		Sharing of operational MDCTs has not been provided to BH providers to allow for access to engaging in case management meetings for those IDN Medicaid beneficiaries with complex health care needs.	By early Fall 2019, the IDN will be sharing the dates and contacts for the MDCT monthly case management meetings being operationalized to enable access for all BH providers, as applicable.
	Progress on Workflow/Protocols for each of the following:	*awaiting attestation	*resource constraints	*once IDN Admin team clinical consultant is on board, provide support to partner for completion of crosswalk
	Interactions between providers and community based organizations	"	"	"
	Timely communications	"	"	"
	Coordination among case managers internal and external	"	"	"
	Safe transitions from institutional settings back to primary care, BH and social support service providers	"	"	"
	Intake procedures that include systematically soliciting patient consent to confidentially share information among providers	"	"	"
	Adherence to NH Board of Medicine guidelines on opioid prescribing	n/a		
	Progress on Additional Integrated Practice designation requirements:			
	Adoption of medication assisted treatment	n/a		
	Adoption of evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model			
	Use of technology to identify, at minimum:			
	At risk patients	*unknown		
	plan care		*not leveraging [redacted] shared care plan platform currently	
	monitor/manage patient progress toward goals	*manually through progress notes	*not leveraging [redacted] shared care plan platform currently	
	ensure closed loop referral		*At this time, there is no comprehensive or standardized Closed Loop Referral technology in place.	*An electronic CLR platform is being evaluated at a state level; some vendors being evaluated: Unite Us & Open Beds; the IDN 3 Data/IT Co-Chair has been involved in this evaluation process; the Data/IT Co-Chair presented his thoughts to the IDN 3 Data/IT Governance Committee; the preference is to take an approach of using a platform which will connect and leverage as much of the state's available resources within one platform as possible
	Documented workflows with community based social support service provides including, at minimum:	*awaiting attestation	*resource constraints	*once IDN Admin team clinical consultant is on board, provide support to partner for completion of crosswalk
	Joint service protocols	"	"	"
	Communication channels	"	"	"
	Progress on use of HIT	*The Youth Council is manually reporting to [redacted] on a regular basis for Assess.01, 02 04; they are not required to report on any of the CY2018 measures. *The Youth Council has been receiving ENS for their Medicaid population through [redacted] since 02/2019 *The Youth Council has DSM capabilities through IDN [redacted] sponshorship		

attachment_B1.8a:
CCSA Domains Covered by IDN Primary Care and Behavioral Health Provider Practices/Organizations

Practice Name	Demographic Information	Physical Health	Substance Use	Housing	Family & Support Services	Educational Attainment	Access to Legal Services	Suicide Risk	Functional Status	Depression	SBIRT	Developmental Screening at 9, 18 and 24/30 months	Bright Futures or AAP Recognized Screen
Dartmouth Hitchcock (DH) Practices													
DH Nashua Internal Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DH Nashua Family Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DH Nashua Pediatrics	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DH Hudson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DH Milford	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DH Merrimack	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Foundation Medical Partners (FMP) Practices													
FMP Amherst Family Practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Downtown Medical Associates	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Hudson Family Practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Milford Family Practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP South Nashua Family Practice	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Internal Medicine Associates of Nashua	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Merrimack Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Nashua Primary Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Nashua West Adult Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Pelham Family Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Internal Medicine at Pelham Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Medicine-Pediatrics of Nashua	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Foundation Pediatrics	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Main St. Pediatrics & Adolescent Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FMP Internal Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Greater Nashua Mental Health Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A
Harbor Homes	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Keystone Hall	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A
LaMora Psychological Associates	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A
Lamprey Health Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Merrimack River Medical Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A
St. Joseph Hospital and Physician Practices (SJH)													
SJH Nashua Family Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SJH Nashua Internal Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SJH Nashua Pediatrics	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SJH Hudson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SJH Milford	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SJH Merrimack	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SJH Adult Medicine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
The Emmaus Institute	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A
The Youth Council	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A

attachment_B1.9c
IDN Member Entity Provider Use of Technology

Provider/Practice	Use of Technology to Identify At-Risk Patients			Use of Technology to Plan Care		Use of Technology to Monitor/Manage Patient Progress Toward Goals		Use of Technology for Ensure Closed Loop Referrals
Technology:	Electronic CCSA	[redacted] ENS/SCP	DSM & Integrated DSM (Part of EHR)	[redacted] ENS/SCP	DSM & Integrated DSM (Part of EHR)	[redacted] ENS/SCP	DSM & Integrated DSM (Part of EHR)	Awaiting [redacted] functionality build or Statewide Closed Loop Referral Vendor decision for this solution
Dartmouth-Hitchcock								
Dartmouth-Hitchcock Nashua Family Medicine	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Nashua Internal Medicine	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Nashua Pediatrics	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Hudson	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Merrimack	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Milford	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Foundation Medical Partners Practices								
Amherst Family Practice	Y	N	Y	N	Y	N	Y	N
Downtown Medical Associates	Y	N	Y	N	Y	N	Y	N
Hudson Family Practice	Y	N	Y	N	Y	N	Y	N
Milford Family Practice	Y	N	Y	N	Y	N	Y	N
South Nashua Family Practice	Y	N	Y	N	Y	N	Y	N
Internal Medicine Associates of Nashua	Y	N	Y	N	Y	N	Y	N
Merrimack Medical Center	Y	N	Y	N	Y	N	Y	N
Nashua Primary Care	Y	N	Y	N	Y	N	Y	N
Nashua West Adult Medicine	Y	N	Y	N	Y	N	Y	N
Pelham Family Medicine	Y	N	Y	N	Y	N	Y	N
Internal Medicine at Pelham Medical Center	Y	N	Y	N	Y	N	Y	N
Medicine-Pediatrics of Nashua	Y	N	Y	N	Y	N	Y	N
Foundation Medical Partners, Foundation Internal Medicine	Y	N	Y	N	Y	N	Y	N
Foundation Pediatrics	Y	N	Y	N	Y	N	Y	N
Main St. Pediatrics & Adolescent Medicine	Y	N	Y	N	Y	N	Y	N
Internal Medicine	Y	N	Y	N	Y	N	Y	N
Greater Nashua Mental Health Center	Y	Y	Y	Y	Y	Y	Y	N
Harbor Health/Harbor Care Health and Wellness Center	N	N	Y	N	Y	N	Y	N
Healthy at Home	N	N	N	N	N	N	N	N
Keystone Hall	N	N	Y	N	Y	N	Y	N
LaMora Psychological Associates	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)
Lamprey Health Care	Y	Y	Y	Y	Y	Y	Y	N
Merrimack River Medical Services	N	N	Y	N	Y	N	Y	N
St. Joseph Hospital Practices								
Pediatrics Nashua	N	N	Y	N	Y	N	Y	N
Pediatrics Milford	N	N	Y	N	Y	N	Y	N
Pediatrics Sky Meadow	N	N	Y	N	Y	N	Y	N
Family Medicine, Nashua	N	N	Y	N	Y	N	Y	N
Internal Medicine	N	N	Y	N	Y	N	Y	N
Family Medicine & Specialty Services Hudson	N	N	Y	N	Y	N	Y	N
Family Medicine & Specialty Services Merrimack	N	N	Y	N	Y	N	Y	N
Family Medicine & Specialty Services Milford	N	N	Y	N	Y	N	Y	N
Adult Medicine	N	N	Y	N	Y	N	Y	N
Southern NH Medical Center	N/A	Y	Y	Y	Y	Y	Y	N
The Emmaus Institute Counseling Services	N (see Note 2)	N (see Note 3)	Y	Y	Y	Y	Y	N
The Youth Council	N (see Note 2)	Y	Y	Y	Y	Y	Y	N
Notes:								
1. DH has contracted with [redacted] for all their practices but Nashua Practices have not completed workplans for [redacted]								
2. Using Paper Version of CCSA								
3. In porgress - expect in Q3 of 2019								

Multi-Disciplinary Team Training Schedule			
Category	**Training**	**Learning Objectives**	**Held**
CCSA/ Universal Screening			
	Addressing Childhood Adversity and Social Determinants in Primary Care	• Pathways by which childhood adversity impacts health • Overview of the report "Addressing Childhood Adversity and Social Determinants in Pediatric Primary Care: Recommendations for New Hampshire" • - Strategies individuals, communities, and the state can take to address childhood adversity and social determinants in New Hampshire	1/25/19
Understanding Addiction			
	Substance Related & Addictive D/O; Module 1 - DSM-5 Criteria & Diagnostic Information Overview	*Receive an overview of DSM-5 criteria and diagnostic information specific to substance use disorders. In addition, the course teaches the alterations that substance use may make to important brain areas needed for life-sustaining functions.	2/25/19
	NH Substance Related and Addictive Disorders Module 4; Cannabis Related Disorders	*Receive an overview of DSM-5 criteria and diagnostic information specific to Cannabis-Related Disorders. In addition, the course teaches the alterations that substance use may make to important brain areas needed for life-sustaining functions.	3/22/19 4/18/19
	NH Substance Related and Addictive Disorders Module 5: Hallucinogen Related Disorders	*Receive an overview of DSM-5 criteria and diagnostic information specific to Hallucinogen-Related Disorders. The course also teaches the alterations that substance use may make to important brain areas needed for life-sustaining functions.	5/16/19
	NH Substance Related and Addictive Disorders Module 6: Inhalant related Disorders	*Receive an overview of DSM-5 criteria and diagnostic information specific to Inhalant-Related Disorders. In addition, the course teaches the alterations that substance use may make to important brain areas needed for life-sustaining functions.	6/19/19
	Substance Related and Addictive Disorders Module 7 - Opioid Related Disorders	*Receive an overview of DSM-5 criteria and diagnostic information specific to Opioid-Related Disorders. In addition, the course teaches the alterations that substance use may make to important brain areas needed for life-sustaining functions.	1/30/19
	Adolescents, Young Adults and Opioid Use: When Is It a Problem? What to Do?	1) vulnerabilities to developing an opioid addiction 2) warning signs that a young person is misusing a prescription 3) conversations (that take 3 minutes or less) that can help prevent misuse of mediation and 4) various options for treatment with the pros and cons of each.	3/14/19
	Adolescent Substance Use: Contemporary Trends in Prevention and Treatment	*Provide a clinically-oriented overview of prevention and treatment strategies and approaches to address adolescents at risk for substance use and to address those with a substance use disorder. The presenter will focus on 1) developmental issues important when working with youth in clinical settings, 2) prevention strategies, and 3) treatment strategies.	4/18/19
	Medication First: Reversing the Epidemic of Opioid-Related Mortality	*Medication First programs get persons with opioid use disorder maintenance medical treatment as quickly as possible and provide voluntary supportive services as needed. A patient's access to medical treatment is not dependent upon psychosocial treatment compliance or unrealistic expectations about the course of treatment and recovery. The Medication First approach is supported by decades of research. It prioritizes client choice in both service selection and	3/20/19

		service participation. There is a strong consensus in the scientific community that expanding the Medication First or "low-threshold" medical approach to opioid use disorder will be essential to reversing the epidemic of opioid-related deaths.	
	The Feasibility & Effectiveness of Drug-Using Peers Distributing Naloxone & Injection Equipment	*The use of peer-based recovery support has grown substantially in the last five years. However, given ongoing high rates of opioid overdose and addiction, another peer-based workforce has not received enough attention: peers who use drugs. Just as there is a long history of peers in recovery supporting peers seeking recovery, there is a similarly long history of drug-using peers helping one another stay safe and alive. This presentation will describe a peer-based program that employs people who use drugs to distribute naloxone and sterile injection equipment in Pittsburgh, PA. It will review basic harm reduction principles, the peer-based program model, and data on program effectiveness.	4/17/19
	Healing Two Generations: Pregnant and Parenting Women with OUD	*Summarizes what makes women's treatment for substance use disorder unique from men's treatment and highlight key issues when providing treatment to women who have opioid use and other substance use disorders. The research that supports the latest clinical care guidelines for women with opioid use disorders, including pregnant women and those with infants, will be summarized including issues of pain management, breastfeeding and neonatal abstinence syndrome/ neonatal opioid withdrawal. Finally, clinical tips for providing trauma-informed care to the dyad will be presented.	4/18/19
	SBIRT for Providers	*Providers discuss the conceptual framework of SBIRT as a public health model and its impact as a system change initiative. Practice for applying concepts to provide screenings, brief interventions, and referrals to treatment will be included.	1/28/19 2/14/19 3/14/19 4/22/19 5/21/19 6/27/19
	From Stigma to Action: An Interdisciplinary Approach to Addressing Substance Use Disorder	*A Discussion of Strategies – including Medication-Assisted Treatment (MAT)	5/31/19
	Integrating Adolescent SBIRT Education into Health Professional Training: Findings from A National Effort to Prepare the Next Workforce	*Develop and evaluate an Adolescent SBIRT Curriculum including a Learner's Guide to Adolescent SBIRT for Instructors and SBI with Adolescents online virtual simulation. The curriculum was implemented in social work and nursing programs participating in a learning collaborative as part of a national workforce development initiative conducted by NORC with funding from the Conrad N. Hilton Foundation. This webinar will present findings from the evaluation of the effectiveness of the adolescent SBIRT education on key outcomes including students' knowledge, attitudes, readiness, confidence, competence, and skills.	5/23/19
	Healing Addiction and Shame Through Self-Compassion	*Gain an ability to differentially define concepts such as shame, guilt, self-compassion and self-esteem and how these relate to addiction.- Demonstrate an understanding of the components of self-compassion and how they affect the psyche.- Utilize mindfulness and self-compassion to manipulate psychic distress through visualizations and simple somatic interventions.	6/26/19
	New England School of Addiction Studies	*Four-day intensive experience to further knowledge, skills, and experience in the field of substance use disorder services; nearly 100 courses are offered; this training opportunity will provide much of the required courses/credits towards MLADC certification; one of the identified goals in the IDN project plans is to increase the number of MLADCs in our workforce, so we have training funds available to support this opportunity	6/3-6/6/19
Care Planning/Care Coordination			

	Basic Motivational Interviewing	*Learn and understand the spirit and principles of MI; Demonstrate and use some basic motivational interviewing skills and tools; Practical application of the basic micro skills and COD treatment; Describe the 4 fundamental processes of motivational interviewing	1/25/19
	Motivational Interviewing	*MI is a partnership approach to facilitate motivation within people to change behaviors. Participants learn elements of MI style and methods of coping with resistance to guide individuals to problem-solve for themselves.	5/7/19
	Community Health Worker Summit	• CHW Certification: Pathways & Decisions • Breakouts: CHW and Stakeholder sessions • CHW Initiatives in NH • National CHW Initiative; Core Consensus Project • NH CHW Coalition and Award • A Mother's Story: Journey to Becoming an Advocate	6/26/19
Co-Occurring Disorders			
	Intersection of Chronic Disease/BH	•Define the latest guidelines for diabetes, hypertension and dyslipidemia •Understand the intersection of behavioral health and chronic disease management •Identify barriers to the integration of behavioral health care and chronic disease management •Identify and utilize strategies to overcome identified barriers	3/6/19
	Advanced Training on Co-occurring Disorders & Recovery	*In-depth review of the principles of Integrated Treatment for COD (ITCOD); Identifying implementation strategies for each; Skills review and practice regarding core skills for ITCOD; Team-based client centered supervision for ITCOD services	1/24/19 1/31/19
	IDN4/Rivier University Spring Lunch & Learn Chronic Condition series:	•Asthma	3/19/19
		•Chronic Pulmonary Disorder (COPD)	3/20/19
		•Diabetes II	3/26/19
		•Congestive Heart Failure	3/28/19
		•Cerebrovascular Accident (CVA)/ Atrial Fibrillation(AFIB)	4/2/19
		•Hypertension	4/16/19
		• Diabetes – pre-recorded	On demand
		• Hyperlipidemia – pre-recorded	On demand
	IDN1: Diabetes Hyperglycemia	*Diabetes Overview for All (Dr. Charles Brackett) – pre-recorded	On demand
	IDN1: Diabetes, Hypertension, Dyslipidemia	*Chronic Disease Management for BH Providers – Diabetes, Hypertension & Dyslipidemia (Tracy Tinker) – pre-recorded	On demand
Mental Health First Aid			
	Adult Mental Health First Aid	• A 5-step action plan to help a person in crisis connect with professional, peer, social, and self-help care • Topics covered include anxiety, depression, psychosis, and addictions, with the focus on those 18 years of age and older. • Using scenarios and role playing, participants are given the opportunity to practice their new skills and gain confidence in helping others who may be developing a mental health or substance use challenge or those in distress.	3/25/19 5/22/19 6/13/19

	Youth Mental Health First Aid	*Designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders	6/18/19
	Youth Mental Health First Aid	*YMHFA, a National Council for Behavioral Health program, teaches a 5-step action plan to offer initial help to young people showing signs of a mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care.	5/9/19
	IDN 2 Mental Health Awareness	*Working in an Integrated Primary Care Practice", an IDN2 developed resource for indirect staff to introduce why it can be difficult for those with behavioral health needs to access and stay engaged in treatment and the cultural shifts and practice changes necessary to integrate care. (upon completion, please link to the survey mentioned at the end of the presentation so we can report who has completed the training)	On demand
	IDN1: Mental Health Awareness	*MH Awareness (Phil Wyzik)	On demand
Cultural Competency			
	Unpacking Assumptions	*Why do we make the assumptions we do? We often do not notice our own assumptions. Although assumptions sometimes increase our efficiency, unfortunately at other times they decrease the quality of care.	3/19/19
	Stigma Across Cultures	*Ever wonder why a person might need Mental Health or Substance Use services but not access them? Let's look at the types of language, attitudes, and behaviors that clients receive and the early years social messaging they receive, across several demographic groups. • Identify three or more demographic groups and at least one way in which each group has experienced difficulty approaching MH or SUD services • Discuss impact of societal stigma and stereotyping on MH and SUD clients • Apply best practices using client cases	4/17/19
	Cultural Effectiveness	• What is Culture • Defining Cultural Effectiveness • Five Elements of Cultural Effectiveness • What is Cultural Humility? • Cultural Practice Model for Effectively Engaging Multicultural Clients	1/18/19
	Cultures Forum	*This program features 3 panelists from different cultural backgrounds who will discuss surprising interactions between patients/clients from their group and healthcare providers. Panelists may include medical interpreters who have seen communications first hand. Their presentations will be geared to helping providers see the issues and how to better serve people from their backgrounds. Learning objectives: a) discuss some surprising interactions that occur between healthcare or other providers and co-cultural community members b) identify best practices that help co-cultural community members comfortably utilize healthcare or other services	1/17/19 3/26/19 4/11/19
	Cross Cultural Behavioral Health	• Discuss at least 3 aspects of culture and how they show up in behavioral health interactions • Identify at least 3 good practices for personal cultural effectiveness and 3 for agency cultural effectiveness	2/26/19 3/21/19

	Culture, Diversity, and Cultural Effectiveness	• Discuss fears or assumptions that family members from the represented cultures may have when seeking services • Discuss the represented cultures perspectives on disability and mental illness • Identify 3 practices on the part of staff that could help community members of the represented cultures more comfortably utilize services	6/11/19 6/13/19 6/26/19
	Culture, Diversity, and Cultural Effectiveness	*training that sets an important foundation for improving staff cultural effectiveness. Inclusive of group activities and discussion, personal reflection, and presentation, this session is a very important one for building trust and motivation in staff for the ongoing walk of cultural competence in their everyday work interactions. It was designed by the NH (DHHS) Office of Health Equity and consultants in Cultural Effectiveness training	3/28/19
	Introduction to Spirituality in Patient Care: How the Mind, Body and Spirit are Interconnected in Healing Physical and Behavioral Health Conditions	*Introductory presentation will raise awareness and understanding of the dynamics and impact of spirituality in the overall care of patients. Participants will leave with a better understanding of why looking at a person as a "living document" provides opportunities for treating the whole person and will have increased knowledge of available screening and assessment tools.	4/29/19 6/12/19

IDN-3 Guidelines & Protocols

V1

Delivery System Reform Incentive Payment (DSRIP)
Integrated Delivery Network (IDN) 3

Required Guidelines & Protocols
Interactions between providers and community based organizations
Timely Communication
Coordination among case managers (internal and external to IDN)
Safe transitions from institutional settings back to primary care, behavioral health and social support service providers
Intake procedures that include systematically soliciting patient consent to confidentially share information among providers
Adherence to NH Board of Medicine guidelines on opioid prescribing
Joint service and communication channels
Privacy, including limitations on information for communications with community based organizations
Treatment of mild to moderate depression
Assessment, management, referrals using technology
Referrals (closed loop)

INTERACTIONS BETWEEN PROVIDERS & COMMUNITY BASED ORGANIZATIONS:

As per the B1 Special Terms and Conditions Minimum HIT Standards, providers must have the ability to secure Patient Health Information (PHI) data in any form (electronic or paper-based) and use the protocol Direct Secure Messaging (DSM) when exchanging PHI between providers. In accordance with state and federal laws:

- Identify what information is provided to treatment providers, what is available to community based organizations and how privacy will be protected.
- The patient has a right to refuse providers outside the practice access to their medical information, thus it is strongly encouraged to have a conversation with the patient why participation in coordinated care may be beneficial to working on their patient centered goals and getting any necessary patient consent.

Closed Loop Referral

There will be use of a formal closed-loop referral process to connect Medicaid Members with Community Based Organizations. The following protocol defines population to be served by level of acuity.

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.

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

Shared Care Plan

A Shared Care Plan will be utilized 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

TIMELY COMMUNICATION:

As per the B1 Special Terms and Conditions, work flows that ensures timely communication of a defined set of clinical and other information critical to diagnosis, treatment and management of care is required. It is expected that communication be enabled via electronic means (e.g., shared EHR or coordinated care management system) or that providers are advancing along a continuum towards electronic communication such usage of the Direct Messaging platform ([redacted] and the [redacted] platforms for Event Notification (ENS) and Shared Care Plan (SCP).

Closed Loop Referral

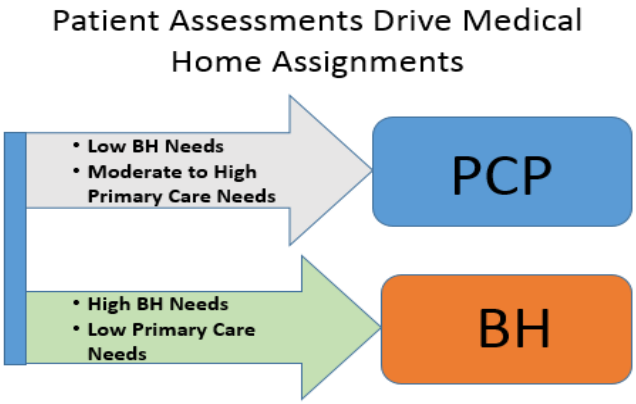
Types of referrals and what is considered timely communication by the IDN:

- **Urgent Referral** – referral that require the patient/client to be seen immediately (the verbal or written handoff is the referral and once completed the referral is considered to be closed)
- **Priority Referral** – referral that require the patient to be seen within 3-11 days (from referral sent to patient seen)
- **Routine Referral** – referral that require the patient to have an appointment scheduled within 28 days – not seen
- **Priority/Routine Patient Preference Referral** – referral with appointments that are not in the specified time period due to patient preference

COORDINATION AMONG CASE MANAGERS (INTERNAL & EXTERNAL TO IDN):

There are multiple case managers who may be involved in a Medicaid Member's health management. These may include Payer/MCO case managers and healthcare organization case managers.
Guidelines to manage shared patients:

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



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

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

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

iv ***Emergency Care*** – medical or surgical can re obtain on an urgent or emergent basis. See table below with care team agreement and role delineation.

Expectations

Primary Care

- Follows principles of Patient Centered Medical Home

- 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

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

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

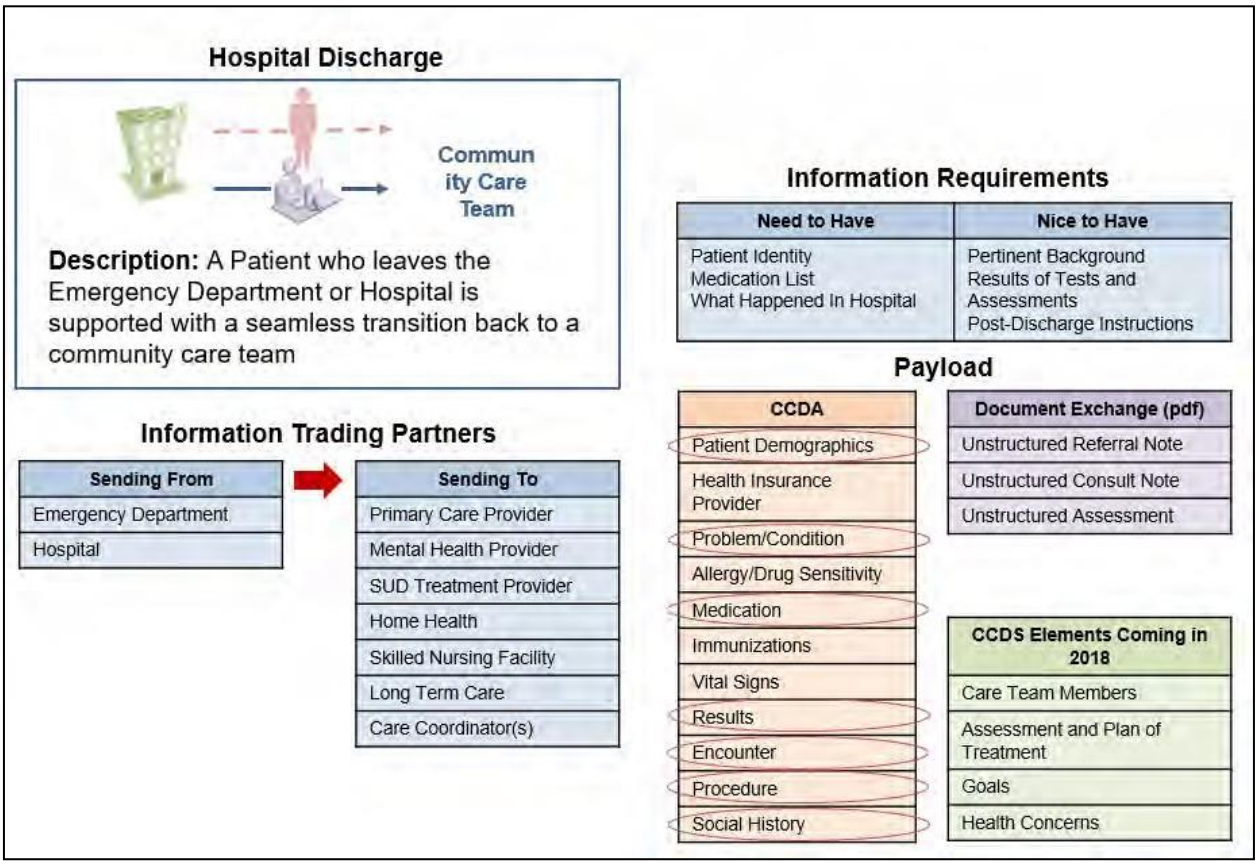
SAFE TRANSITIONS FROM INSTITUTIONAL SETTINGS BACK TO PRIMARY CARE, BEHAVIORAL HEALTH AND SOCIAL SUPPORT SERVICE PROVIDERS:

Safe transitions include workflows with network partners to facilitate safe transitions from institutional settings back to primary care, behavioral health, and social support service providers.

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*:



It is recommended to align 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.

INTAKE PROCEDURES THAT INCLUDE SYSTEMATICALLY SOLICITING PATIENT CONSENT TO CONFIDENTIALLY SHARE INFORMATION AMONG PROVIDERS:

Most providers have established intake procedures. The 1115 Waiver introduces several components for patient care which may not be currently incorporated:

- A Comprehensive Core Standard Assessment (CCSA)
- Care Coordination and Shared Care Planning which may require additional patient conversation and consent

The SAMHSA model divides the delivery into 3 domains of work: pre-visit, visit, and between visit work. Consider the following for the first two domains.[1]

Pre-visit

Care team planning for the visit: assist patient to prepare for visit:[1]

- Bring medications to visit
- Prepare questions to ask provider
- Come in for pre-visit lab tests
- Invite family member/caregiver to visit if patient prefers
- Confirm need for interpreter

Visit

Patient encounter with care team and clinician(s): the "visit" constitutes the time the patient checks in to the time patient departs from the health center and should include the following:[1]

- Give intake form(s) to the patient: meds, allergies, family history, past medical history Assess patient's educational needs
- If not already done, provide NOTICE TO MEDICAID PATIENTS literature regarding your organization's participation in the Building Capacity for Transformation 1115 Medicaid Waiver and what it means for the patient
- Solicit any patient consent necessary to confidentially share information among providers (see more details in the Privacy and Patient Confidentiality Considerations sections)
- Give med reconciliation list to patient and verify pharmacy
- Conduct a Comprehensive Core Standard Assessment (CCSA)
- Help patients/clients identify their goals for the visit and for their health
- Share care plan with Pt/client and discuss establishing or reviewing patient centered goals
- Provide appropriate educational/self- management tools for patient
- Give after visit summary to patient and review with the patient
- Discuss any recommended referrals or follow up actions based on the CCSA outcomes
- Assist in scheduling patient for primary care follow-up, specialty appointments, etc.

[1] Source: IDN 4 Integrated Healthcare Delivery Protocols Best Practices Recommendations_122018.docx

ADHERENCE TO NH BOARD OF MEDICINE GUIDELINES ON OPIOID PRESCRIBING:

IDN3 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.

IDN3 promotes use of the following resources with Partners that are updating their processes for opioid prescribing:

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

JOINT SERVICE & COMMUNICATION CHANNELS:

IDN3 has worked with its Integrated Healthcare Partners to encourage formalization of joint service and communication channel practices between primary care, behavioral health, and community based social support service providers. It has emphasized that when interoperability and delivery system transformation are embraced, the goal of improving population health across care settings and provider organizations is more likely to occur. Given many workflows and protocols already existed, some were refined or are embedded within larger overarching protocols or work plans. For those practices who do not have existing joint service and communication channel protocols in place, IDN3 can provide a Collaborative Care Agreement template that can be easily adapted and edited to fit all B1 Integrated Healthcare Partner and community based social service provider needs.

Additionally, with IDN3 B1 Integrated Healthcare Partners implementing the use of [redacted] ([redacted] software, it widely and naturally supports communication channels through its capabilities for shared care planning, care coordination, hospital emergency department event notification, being a collection site for social determinants of health data among the partners in our region and across the state. The use of [redacted] not only increases collaboration and interoperability between clinical and social service partners in communities, but is already proving successful in better addressing patients' social determinants of health and reducing avoidable hospital use.

- If your organization does not have a formalized joint service and communication channel with community based social service providers protocol(s) in place, please follow the steps below:
  - Contact IDN3 Program Director, Michele Craig at craigmi@snhhs.org to obtain the IDN3 *Collaborative Care Agreement* template to adapt for your individual practice needs

PRIVACY, INCLUDING LIMITATIONS ON INFORMATION FOR COMMUNICATIONS WITH COMMUNITY BASED ORGANIZATIONS:

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

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 electronic health record (HER) text fields for users of electronic health records (EHRs).

TREATMENT OF MILD TO MODERATE DEPRESSION:

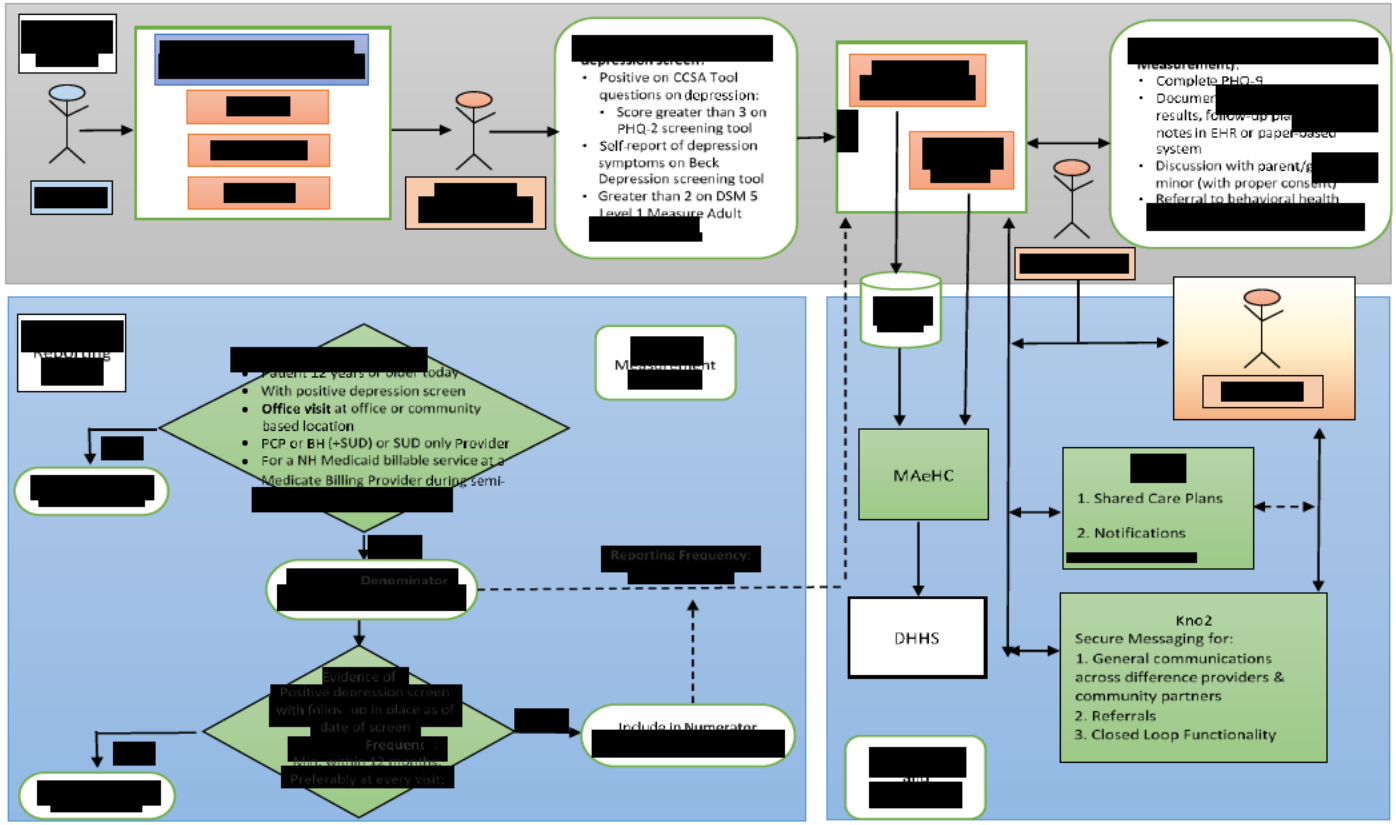
Key IDN Considerations	IDN Recommendation/Policy	Notes
Which IDN treatment providers are required to complete screening and have a follow-up plan in place for potential **depression** diagnosis and how often?	Required IDN Member Entities (ALL of the below): • Primary Care Billable Providers • Mental Health Care Billable Providers • Substance Use Disorder (SUD) Billable providers	Per DSRIP measures, all IDN primary care and behavioral health provider partners must complete depression screening and have a follow-up plan documented in the patient's electronic health record (EHR) on the date of the positive screening. Per DSRIP measures, all IDN primary care and behavioral health provider partners must report data for this measure, which has two sub-measures: depression and SUD screening.
	Recommended frequency: • Minimally: Once every 12 months • Preferred: Every office visit*	*Per DSRIP Outcome Measure Specifications (DSRIP Measures), The CCSA is minimally required once every 12 months. Although the goal is for all patients to come in for annual visits, the reality is that many patients may not and are only seen when acute conditions arise or circumstances may change from the last visit so it is recommended that the CCSA frequency is at every office visit
What constitutes approved tools and a positive **depression** screen by the IDN?	Recommended tools/protocols (select ONE of the below): • Positive on CCSA Tool questions on depression which are PHQ2 screening questions where a score greater than 3 is considered a positive screen • PHQ2 screening tool administered outside of the CCSA tool where a score greater than 3 is considered a positive screen • Self- report of depression symptoms on Beck Depression screening tool • Greater than 2 on either DSM 5 Level 1 Measure Adult screening tool (for **18 years and older**) or DSM 5 Level 1 Measure – Child Age 11-17 screening tool (for **12-17 years old**) • Or IDN approved evidence based question in provider's specific EHR system	Potential reasons for exclusion from documented guidelines: • Patient refuses to participate in the follow-up plan; • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; • Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools. For example: certain court appointed cases or cases of delirium; or • Any other exclusion documented in the IDN's approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.
What constitutes an appropriate follow-up plan in place for a positive **depression** screen by the IDN and example referral pathways?	Recommended IDN policy for follow-up intervention (select ONE or MORE below): • Patients who screen positive on PHQ-2 (or Beck Depression screening tool), should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder • Develop a follow up intervention plan with patient at the time of the screening. • Refer anyone with moderate depression or higher for immediate behavioral health assessment and further treatment • Follow up with client - check if client made the recommended referral appointment if applicable • Refer to community support services if applicable such as peer support, community organizations, and faith based supports • Provide education materials on depression concerns and wellness • Discuss results with parent/guardian, if patient is a minor (with proper informed consent)	Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made Example Pathways for Referral (not comprehensive): • Lamprey Health Care or InteGreat • GNMHC - Community Council (Links under "Services" & "Resources") • Dartmouth Hitchcock • SNHMC BH • Harbor Homes • NAMI

	Recommended IDN follow-up documentation method (select ONE or MORE below):
	
	• Document screening/assessment results, intervention/follow-up plan and progress notes in:
	  ○ organization's Electronic Health Record (EHR) and/or
	  ○ paper-based system	

CCSA Screening Tool for Depression

***1. Question Origin**: PHQ-2*				
Over the *last 2 weeks*, how often have you been bothered by:	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, or hopeless?	☐	☐	☐	☐

Depression Screening with Follow-up In Place Component Flow



ASSESSMENT, MANAGEMENT, REFERRALS USING TECHNOLOGY:

Information Sharing

Coordinated care requires the ability to share information regularly among all types of providers for care planning, treatment planning and for conducting case conferences. These workflows must be documented and ensure timely communication, incorporating a communication plan. Technology can help to aid and streamline some of the critical steps in coordinated care and closed loop referral process. For the purpose of information sharing, the NH Building Capacity for the 1115 Waiver has defined some minimum HIT requirements which include the ability to:

- use the Direct Secure Messaging (DSM) Protocol to transmit Patient Health Information (PHI) securely between providers
- transmit and receive event notifications for any hospital Admissions, Discharge and Transfer (ADT) vents
- access and/or contribute to an electronic shared care plan for an individual patient

The following vendors have been approved by IDN IT/Data Governance Committee for Direct Secure Messaging and Event Notification (ENS)/Shared Care Plans (SCPs).

Direct Secure Messaging

[redacted] is a Direct Secure Messaging (DSM) Platform which is required to:

- Provide the ability to transmit protected health information (PHI) between IDN Member Entity Providers securely over a trusted and encrypted network.
- Allow sending and receiving of referrals securely between and across providers for individual patients
- Provide electronic closed loop referral capabilities (in development)
- Providers directly sub-contract with [redacted] and follow policies agreement upon based on the business or service agreement.

Event Notification and Shared Care Plan Services

The [redacted] ([redacted] vendor platform supports both Event Notification Services (ENS) and Shared Care Plan (SCP) implementation:

- Event Notification Services allows providers to receive notifications through an automated service that provides timely alert messages when patients are admitted/discharged from a hospital or emergency department. These notifications are customizable and allows the provider to subscribe to an IDN attributed Medicaid patient in its panel. The provider will then receive (and in some cases, provide) alerts related to their patients' medical service encounters.
- The [redacted] Shared Care Plan is an electronic tool for information sharing between providers for case management and treatment plan implementation across a Multi-Disciplinary Core Team. This allows IDN Member Entity treatment and social services support providers to engage in contributing to and/or viewing an electronic care plan where role based care management access is utilized to address complex patient care.
- Two Platforms: Pre-Manage ED (for hospital settings which transmits ADTs & Pre-Manage for ambulatory settings which has the ability to receive ADTs (event notifications) & shared care plan functionality.
- Providers directly sub-contract with [redacted] and follow policies agreement upon based on the business or service agreement

Event Notification Services – EDie

[redacted] Pre-Manage EDie is for the hospital setting where notifications are transmitted through an automated service that provides timely alert messages when patients are admitted/discharged/transferred from a hospital (in-patient) or emergency department.

Event Notification Services - Ambulatory

[redacted] Pre-Manage (Ambulatory) Event Notification Service allows providers to receive notifications through an automated service that provides timely alert messages when patients are admitted/discharged/transferred from a hospital (in-patient) or emergency department. These notifications are customizable and allows the provider to subscribe to an IDN attributed Medicaid patient in its panel. The provider will then receive alerts related to their patients' hospital medical service encounters.

IDN 3 Specific Guidelines

The following are additional IDN 3 information sharing guidelines:

- Providers should share the NOTICE TO MEDICAID PATIENTS literature (see Intake Procedures for further details) to educate them on the ideals of the 1115 Waiver
- For receiving event notifications and the ability to view content already in a care plan, the IDN 3 guidelines is to follow the [redacted] [redacted] policies as per the service agreement executed between the provider and [redacted]
- For the ability to enter into a shared care plan, the IDN 3 guidelines require providers acquire patient consent (see patient consent template in the Appendix)
    - Consider starting the dialog about sharing patient centered goal(s) so that all on the care team are on the same page and supporting that goal.
- For entering any 42CFR Part 2 or NH State Sensitive Information, providers should acquire patient consent detailed in the [redacted] ([redacted] policies as per the service agreement executed between the provider and [redacted] (please see Appendix for the [redacted] Patient Consent Form).

REFERRALS (CLOSED LOOP):

Myers and Stauffer references seven principles from the Institute for Healthcare Improvement and National Patient Safety Foundation (IHI & NPSF) study ("Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era") for all stakeholders:

- Design the referral process with the patient and family at the center;
- Create and communicate expectations, accountability and responsibility for adopting a closed-loop referral process including clarification of expected wait times at each phase;
- Implement consistent and coherent workflows;
- Minimize administrative burden;
- Employ user-centered design principles when creating or modifying electronic health records (EHRs) for referrals;
- Ensure seamless information flow by addressing interoperability issues; and
- Measure the effectiveness and safety of the referral process.

Based on the above objectives, organization will need to assess if they have workflows in place which support a closed loop referral process, whether it be via electronic, or non-electronic means. These workflows will ensure that the referring provider has a way to track a referral, monitor the referral process, receive the consultant's report, and communicate with the patient keeping the following components in mind for a successful closed loop referral:

- Scheduling of appointment
  - Who schedules: referring provider, patient or receiving provider?
- Sending referral to specialty care in a timely manner with minimal supporting information included
  - Minimal summary of care referral information along with Referral Type
- Receiving provider feedback to referring provider
  - Minimal guideline is to notify referring provider that patient has been seen
  - More details of the visit/outcome can also be provided
- Closing the referral
  - For normal flow, minimal guideline is close referral once referring provider is notified of patient being seen
  - For more complex scenarios, at what point should follow up happen and by whom?
- Documenting the referral
  - Use of existing electronic health record (EHR) documenting outcomes of the referral (no show, waived; attended; follow up action executed) either manually or electronically
  - Use of IDN recommended closed loop referral tool such as [redacted]
- Follow-up: understanding and developing plan to support the more complex scenarios
  - The “no show” scenarios
  - Those who require more support in completion of each of the steps
  - Delayed referral times
  - Unavailability of needed referral resource

*Please refer to the *IDN 3 Closed Loop Referral Guidelines V1.4* document for more detailed guidelines.

**appreciation to IDN1 & IDN4 for their willingness to share their guidelines & protocols for reference in this document*

Provider/Practice	Use of Technology to Identify At-Risk Patients			Use of Technology to Plan Care		Use of Technology to Monitor/Manage Patient Progress Toward Goals		Use of Technology for Ensure Closed Loop Referrals
Technology:	Electronic CCSA	[redacted] ENS/SCP	DSM & Integrated DSM (Part of EHR)	[redacted] ENS/SCP	DSM & Integrated DSM (Part of EHR)	[redacted] ENS/SCP	DSM & Integrated DSM (Part of EHR)	Awaiting [redacted] functionality build or Statewide Closed Loop Referral Vendor decision for this solution
Dartmouth-Hitchcock								
Dartmouth-Hitchcock Nashua Family Medicine	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Nashua Internal Medicine	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Nashua Pediatrics	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Hudson	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Merrimack	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Dartmouth-Hitchcock Milford	Y	N (see Note 1)	Y	N (see Note 1)	Y	N (see Note 1)	Y	N
Foundation Medical Partners Practices								
Amherst Family Practice	Y	N	Y	N	Y	N	Y	N
Downtown Medical Associates	Y	N	Y	N	Y	N	Y	N
Hudson Family Practice	Y	N	Y	N	Y	N	Y	N
Milford Family Practice	Y	N	Y	N	Y	N	Y	N
South Nashua Family Practice	Y	N	Y	N	Y	N	Y	N
Internal Medicine Associates of Nashua	Y	N	Y	N	Y	N	Y	N
Merrimack Medical Center	Y	N	Y	N	Y	N	Y	N
Nashua Primary Care	Y	N	Y	N	Y	N	Y	N
Nashua West Adult Medicine	Y	N	Y	N	Y	N	Y	N
Pelham Family Medicine	Y	N	Y	N	Y	N	Y	N
Internal Medicine at Pelham Medical Center	Y	N	Y	N	Y	N	Y	N
Medicine-Pediatrics of Nashua	Y	N	Y	N	Y	N	Y	N
Foundation Medical Partners, Foundation Internal Medicine	Y	N	Y	N	Y	N	Y	N
Foundation Pediatrics	Y	N	Y	N	Y	N	Y	N
Main St. Pediatrics & Adolescent Medicine	Y	N	Y	N	Y	N	Y	N
Internal Medicine	Y	N	Y	N	Y	N	Y	N
Greater Nashua Mental Health Center	Y	Y	Y	Y	Y	Y	Y	N
Harbor Health/Harbor Care Health and Wellness Center	N	N	Y	N	Y	N	Y	N
Healthy at Home	N	N	N	N	N	N	N	N
Keystone Hall	N	N	Y	N	Y	N	Y	N
LaMora Psychological Associates	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)	N/A (see Note 4)
Lamprey Health Care	Y	Y	Y	Y	Y	Y	Y	N
Merrimack River Medical Services	N	N	Y	N	Y	N	Y	N
St. Joseph Hospital Practices								
Pediatrics Nashua	N	N	Y	N	Y	N	Y	N
Pediatrics Milford	N	N	Y	N	Y	N	Y	N
Pediatrics Sky Meadow	N	N	Y	N	Y	N	Y	N
Family Medicine, Nashua	N	N	Y	N	Y	N	Y	N
Internal Medicine	N	N	Y	N	Y	N	Y	N
Family Medicine & Specialty Services Hudson	N	N	Y	N	Y	N	Y	N
Family Medicine & Specialty Services Merrimack	N	N	Y	N	Y	N	Y	N
Family Medicine & Specialty Services Milford	N	N	Y	N	Y	N	Y	N
Adult Medicine	N	N	Y	N	Y	N	Y	N
Southern NH Medical Center	N/A	Y	Y	Y	Y	Y	Y	N
The Emmaus Institute Counseling Services	N (see Note 2)	N (see Note 3)	Y	Y	Y	Y	Y	N
The Youth Council	N (see Note 2)	Y	Y	Y	Y	Y	Y	N
Notes:								
1. DH has contracted with [redacted] for all their practices but Nashua Practices have not completed workplans for [redacted]								
2. Using Paper Version of CCSA								
3. In porgress - expect in Q3 of 2019								

Projects C: Care Transitions-Focused

attachment_C.1a: IDN Community Project Implementation Plan
attachment_C.9a: Critical Time Intervention (CTI) Training Plan
attachment_C.9b: CTI Supervisor Training Slides

attachment_C.1a:
IDN Community Project
Implementation Plan

Status	Task Name	Comments
Complete	Stage 1: Project Planning and Process Milestones (Development of Implementation Plan) January to June 2017	
Complete	I. Develop implementation timeline	
Complete	II. Develop project budget	
Complete	III. Develop workforce plan	
Complete	III. Identify projected annual client engagement volumes	
Complete	IV. Identify key organizational/provider participants	
Complete	Stage 1: Project Planning and Process Milestones (Design and Develop Clinical Services Infrastructure) January to June 2017	
Complete	I. Identify/develop standardized protocols and workflows for Critical Time Intervention (CTI) model, including patient identification criteria, standardized care transition plan, case worker guidelines and standard processes for each of the program's three phases	
Complete	II. Identify/develop roles and responsibilities for CTI team members	
Complete	III. Develop CTI team training plan	
Complete	IV. Identify training curricula	
Complete	V. Develop agreements with collaborating organizations	
Complete	VI. Develop evaluation plan	
Complete	VII. Identify mechanisms (registries) to track and monitor individuals served by the program, adherence to the program fidelity and process/outcome measures	
Complete	A. Identify HIT vendor platform to be used for ENS and SCP: [redacted] - [redacted] through [redacted]	
Complete	B. GNMHC sets up tracking mechanism in EHR as [redacted] contracting, policies and protocols are completed	
In progress	C. GNMHC determines if they will utilize [redacted] for Direct Secure Messaging and Electronic Direct Secure Messaging for sharing PHI among IDN treatment providers or use their own integrated DSM within their EHR for CTI patients	
In progress	Stage 1: Project Planning and Process Milestones (Operationalization of Program) July to December 2017	
In progress	I. Implementation of workforce plan	.5 FTE CTI Specialist still remains unfilled, due to client enrollment not warranting the need
Complete	A. Develop job descriptions and roles for CTI team members	
Complete	B. Implement recruitment/hiring efforts, including IDN Career Fair and Job Board on IDN Website	
Complete	C. Onboard CTI Team members	3.65 FTEs, including Clinical Supervisor, Team Lead/Coordinator, and Specialists/Case Managers
In progress	II. Deployment of training plan	
Complete	A. Train CTI staff (Coordinator and Specialists) in CTI model fidelity and core competencies	
Complete	A1. CTI Staff Training	
Complete	A2. CTI Supervisor Training	
Complete	A3. Motivational Interviewing Training	
In progress	B. Train CTI staff in core competencies for multi-disciplinary core team (MDCT) members	
In progress	B1. Team members participate in multi-disciplinary core team (MDCT) training on HIPAA, Safe Sharing of Protected Health Information and 42 CFR Part 2	
In progress	B2. Team members participate in multi-disciplinary core team (MDCT) training the use of IDN HIT Platforms to support information sharing and care coordination	
In progress	B3. Team members participate in multi-disciplinary core team (MDCT) training on the CCSA and universal screening	
Complete	B4. Team members participate in multi-disciplinary core team (MDCT) training on cultural competency and adaptation	
In progress	B5. Team members participate in multi-disciplinary core team (MDCT) training on care planning and care coordination	
In progress	B5a. Care planning/care coordination training: staff educated about the best practices and specific needs applicable to the target sub-population served by the IDN	expected to be completed by December 31, 2018
In progress	B6. Team members participate in multi-disciplinary core team (MDCT) training on co-occurring disorders	
Complete	B8. Team members participate in multi-disciplinary core team (MDCT) training on understanding addiction	Initial Training on Addiction scheduled for 5.10.18
In progress	C. Engage CTI team in statewide CTI Community of Practice (CoP) facilitated by [redacted]	
In progress	C1 Participate in monthly webinar/phone CoP calls	
Complete	C1a. 2017	
Complete	C1b. 2018	
In progress	C1c. 2019	
	January 2019	
	February 2019	
	April 2019	
	May 2019	
	July 2019	
	August 2019	
	October 2019	
	November 2019	
In progress	C2. Participate in quarterly in-person CoP meetings	
Complete	C2a. 2018	
In progress	C2b. 2019	
	March 2019	
	June 2019	
	September 2019	
	December 2019	
Complete	D. Engage CTI team in one-on-one implementation coaching with [redacted]	up to 5 hours allocated in IDN budget
In progress	E. Build sustainability of model through providing train-the-trainer training conducted by [redacted]	
In progress	E1. Training targeted for trainers of future CTI staff provided by [redacted]	scheduled for August 23 and 24, 2018 with up to 4 participants from IDN 3
In progress	III. Implementation of any required updates to clinical protocols, or other operating policies and procedures	
Complete	A. Identify and implement protocols for patient consent and privacy	
In progress	B. Implement education, workflows and protocols for patient identification criteria with referral partners	
In progress	B1. Finalize and pilot referral protocol, including roles and responsibilities	This tool has been revised several times and is being piloted at SNHMC, NH Hospital, and the DRFs
In progress	B1a. Southern NH Medical Center	Currently in pilot phase, with the expectation to review again by September 2018
In progress	B1b. NH Hospital	Currently in pilot phase, with the expectation to review again by September 2018
Not started	B1c. St. Joseph Hospital	St. Joseph Hospital has been in the middle of an EHR migration and is expected to engage with the CTI team Summer 2018, after the "go-live" has been completed in May 2018
In progress	B1d. Designated Receiving Hospitals (DRFs)	
In progress	Elliot Hospital	Currently in pilot phase, with the expectation to review again by September 2018
In progress	Portsmouth Regional Hospital	Currently in pilot phase, with the expectation to review again by September 2018
In progress	Cypress Center	

In progress	C. Implement use of screening/assessment, treatment, management, and referral protocols for CTI patients	
In progress	C1. Develop and pilot referral protocols and workflows, including roles and responsibilities of staff	
In progress	C1a. Southern NH Medical Center	
In progress	C1b. NH Hospital	
Not started	C1c. St. Joseph Hospital	St. Joseph Hospital has been in the middle of an EHR migration and is expected to engage with the CTI team Summer 2018, after the "go-live" has been completed in May 2018
In progress	C1d. Designated Receiving Hospitals (DRFs)	
In progress	Elliot Hospital	Began meeting with team in January 2018 and has been piloting during this reporting period
In progress	Portsmouth Regional Hospital	Began meeting with team in April 2018 and has been piloting during this reporting period
In progress	C2. Develop referral tool for patients not eligible for CTI	Currently in use as part of workflows and protocols being piloted
In progress	C3. Use of Adult Needs and Strengths Assessment (ANSA) to support development of patient-centered plan	Operational, but only for determination of eligibility for CMHC services, not part of CTI protocols
In progress	C4. Use of existing CTI tools provided by [redacted]	Currently in use as part of workflows and protocols being piloted
In progress	C4a. Use of CTI Phase Plan Tool	Currently being piloted by CTI Specialist who identifies the 3 focus areas with goals mutually agreed upon with the patient/client, including psychiatric treatment/medication management; substance use treatment; daily living skills training; housing crisis prevention and management; money management; and family interventions.
In progress	C4b. Use of CTI Phase-Date Form	Currently being piloted by the CTI Coordinator to track patients/clients and the phases they are in to monitor appropriate caseload fidelity; the Specialist also utilizes a spreadsheet to monitor and track client progress and disposition.
In progress	C4c. Use of CTI Progress Note Form	Currently being piloted by the CTI Specialist as part of the phase plan implementation, including documenting ongoing interactions with the patient/client, their providers and social service support organization resources.
In progress	C4d. Use of Closing Note Form	Currently on hold, as no clients have completed the 3 CTI phases.
In progress	C5. Identify workflow for sending referrals via [redacted] direct secure messaging and documentation of closed loop referral	Currently being developed with the CTI team as part of the broader CCSA process and the use of [redacted] for DSM has not yet begun.
In progress	C5a. Formalize standardized protocols for closed loop referrals for clients in CTI program	Referrals are currently being tracked via EHR and excel spreadsheet; standardized workflows for closed loop referrals are being developed, but has been slowed down due to turnover of CTI Coordinator position.
In progress	C6. Identify workflows for populating [redacted] Shared Care Plan platform with referral information, if applicable	Currently being developed as part of contracting with [redacted] and development of SFY 19 IDN sub-contract
In progress	C6a. Formalize protocols and workflows for use of SCP in conjunction with CCSA process implementation	IDN sub-contracts were executed late in the reporting period, so it is expected that the GNMHC contracting with [redacted] (master service agreement and BAA/QSOA) will be completed by August 31, 2018
In progress	C7. Use of CTI Case Management Assessment as ongoing monitoring tool	Currently in use with review in September 2018
In progress	D. Develop case worker guidelines for assessment, treatment, management and referral protocols and workflows	
In progress	D1. Develop policy/protocol for determination of eligibility for which patient(s) will be part of monthly case management meeting	SCP/Case Management Work Team will also be working on this, so makes sense to combine efforts.
In progress	D1a. Conduct team meeting with sub-group of SCP/Case Management Work Team to make recommendations	Discussion occurred as part of April 2018 SCP/Case Management Work Team meeting, with decision to be made as further discussions are conducted with IDN Clinical Committee
In progress	D1b. Make recommendation to IDN Clinical Governance Committee for formal	Expected by September 30, 2018
In progress	D2. Develop case management meeting protocols/policies and workflow	
In progress	D2a. Identify potential IDN Multi-Disciplinary Core Team members who could participate in monthly team meeting, depending upon patient and identified needs	Discussed as part of April 2018 SCP/Case Management Work Team meeting, with decision to be made as further dicussions are conducted with Clinical Committee
Complete	D2ai. Case management meetings held with GNMHC's ACS and FEP programs	
Complete	D2aii. Case management meeting held with St. Joseph Hospital and GNMHC's FEP with a client referral for CTI	
In progress	D2aiii. Case management meeting to be held July 2018 with The Emmaus Institute	
In progress	D2aiv. Case management meeting to be held July 2018 with Gateways Community Services	
In progress	D2b. Set regular meeting date monthly for potential care team members to get into their calendars	Discussed as part of April 2018 SCP/Case Management Work Team meeting, with decision to be made as further dicussions are conducted with Clinical Committee
In progress	D2c. Develop patient informed consent form specific to case management meetings	IDN has created a template form which is currently being vetted through primary care provider organization Compliance Officers, with IDN Clinical Committee expected to approve by Summer 2018
In progress	D2d. Identify lead staff to coordinate meeting, including invitations to key participants, securing patient consent, and outlining key agenda items, as well as providing follow-up with team, as necessary	Discussed as part of April 2018 SCP/Case Management Work Team meeting, with decision to be made as further dicussions are conducted with Clinical Committee
Complete	IV. Use of mechanisms to track and monitor individuals served by the program, as well as manage patient goals and treatment plan among care team	
Complete	A. Use of EHR for implementation of assessment, treatment, management and referral protocols	
In progress	B. Implementation of [redacted] for DSM and Electronic DSM for sharing PHI among IDN treatment providers or use their own integrated DSM within their EHR for CTI patients	
Complete	B1. Execute contract with [redacted]	Executed
In progress	B2. Develop workflows and protocols for use of DSM to coordinate care across care team	Currently in process, as will be utilized as part of CCSA process implementation. Expected to be completed by September 30, 2018
In progress	C. GNMHC implements [redacted] for tracking and monitoring	
In progress	C1. GNMHC completes Master Services Agreement and Business Associate Agreement (BAA) directly with [redacted] (IDN sponsors cost of platform)	expected to be executed by August 30, 2018 now that IDN sub-contract has been executed
In progress	C2. GNMHC works with their EHR vendor and [redacted] to connect interfaces for in-bound and out-bound ADTs	funding for interface setup for both in-bound and out-bound is provided by IDN Admin Lead through A2: HIT budget, so expected to be in tested and operational no later than October 30, 2018
In progress	C3. CTI Specialists and/or CTI Coordinator manually input information into Shared Care Plan for CTI patients and sets registry function within [redacted] platform for ADTs and event notifications for subscribers of patients	Expected to be operational by October 30, 2018, as with staffing turnover of CTI Coordinator, and IDN sub-contract just having been completed late in May 2018 this has been delayed.
Complete	Stage 2: Project Utilization Milestones (Initiation of Data Reporting) July to December 2017	
Complete	I. Report on number of individuals served (during reporting period and cumulative) vs. projected	
Complete	II. Report on number of staff recruited and trained (during reporting period and cumulative) vs. reported	
In progress	IV. Report on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	
In progress	A. CTI team is on target with development of measurement tools and monitoring processes to ensure fidelity of CTI	
In progress	B. CTI team will continue to work through common tools and monitoring processes with 4 other IDNs conducting CTI through Community of Practice (CoP)	
Complete	Stage 2: Project Utilization Milestones (Ongoing Data Reporting) January to June 2018	
Complete	I. Number of individuals served (during reporting period and cumulative) vs. projected	
Complete	II. Number of staff recruited and trained (during reporting period and cumulative) vs. projected	
In progress	III. Staff vacancy and turnover rate for period and cumulative vs. projected	
In progress	A. .5 staff vacancy (CTI Specialist) and .8 turnover rate (CTI Coordinator) vs. 0 projected	CTI Coordinator is expected to be filled at 1 FTE by Fall 2018, with a decision about the role the .5 FTE CTI Specialist will fill (case manager vs. peer support)
In progress	IV. Impact measures as defined in evaluation plan	
In progress	A. Up to 100 clients (up to 4 per month) are engaged in CTI annually 2018 - 2020, ensuring fidelity to model is met, with up to 24 by June 30, 2018.	

In progress	B. Up to 5 IDN clinical and/or behavioral health providers are trained in the available tools and techniques to assess appropriateness of attributed IDN patients participating in Critical Time Intervention (CTI) program strategies in the IDN by June 30, 2018.	In progress: 23 clients referred to date, with 10 enrolled and 2 pending enrollment as of the end of the reporting period.
Complete	C. Up to 5 behavioral health providers are trained in the available tools to assess, treat and manage attributed IDN patients participating in Critical Time Intervention (CTI) strategy in the IDN by June 30, 2018.	Progress met: 4 IDN Member Entity partners were trained by [redacted] between the November 15-15, 2017 and March 19-20, 2018 CTI Staff Trainings.
Complete	D. Up to 5 behavioral health providers are trained in the available tools to assess, treat and manage attributed IDN patients participating in Critical Time Intervention (CTI) strategy in the IDN by June 30, 2018.	Progress met: 3 IDN Member Entity partners were trained by [redacted] December 18, 2017 for the CTI Supervisor Training.
Complete	E. The CTI team engages in cross-learning among the 5 IDN regions conducting the CTI strategy through participating in monthly Community of Practice (CoP) sessions provided by [redacted]	Progress met: All CTI staff engaged in monthly CoP sessions via webinar, as well as the March (Plymouth) and June (Concord) in-person sessions.
Complete	F. Up to 5 behavioral health providers are more aware of the available tools to refer attributed IDN patients participating in the Critical Time Intervention (CTI) strategy by June 30, 2018.	Progress met: All CTI staff have been trained by [redacted] in the CTI Staff training between the November 2017 and March 2018 trainings.
In progress	G. Up to 2 care coordinators/case managers are trained in the use of the available HIT platforms (ENS, DSM, SCP and data aggregation) to support information sharing and communication by June 30, 2018.	Progress not met: While a training on the use of the [redacted] data portal was held in January 2018, no care coordinators/case managers participated. Other trainings are expected in the last half of 2018 related to the HIT platforms that are supporting information sharing and communication.
In progress	H. All patients engaged in CTI will report an increase in utilization of needed community-based services such as housing assistance, legal assistance, family and support services and employment assistance, if applicable to their individual needs, as a result of participating in CTI.	In progress: The team is determining the indicators and tracking process for this target.
In progress	I. Up to 3 case management meetings will be held in the IDN to support the knowledge-building and resource building skills of behavioral health case management and care coordinators by June 30, 2018.	In progress: The team held a case management meeting with The Emmaus Institute in May 2018 to discuss a CTI client who is receiving services from both organizations, but was in need of additional services.
In progress	J. Up to 50% of clients in CTI are engaged in a stable housing plan, if applicable to their individual needs.	In progress: The team is determining the indicators and tracking process for this target.
In progress	K. Up to 75% of clients in CTI will not revisit an emergency department for an avoidable visit or NH Hospital while engaged with their CTI Specialist and care team.	In progress: The team is determining the indicators and tracking process for this target.
In progress	L. Up to 75% of clients enrolled in CTI will attend their initial mental health center intake appointments after discharge from the Emergency Department or NH Hospital.	In progress: The team is determining the indicators and tracking process for this target.
Not started	VI. Ongoing Data Reporting	
Not started	A. Number of individuals served (during reporting period and cumulative) vs. projected	
Not started	B. Number of staff recruited and trained (during reporting period and cumulative) vs. reported	
Not started	C. Staff vacancy and turnover rate for period and cumulative vs. projected	
Not started	D Impact measures as defined in evaluation plan	

attachment_C.9
IDN Community Project
Training Plan

Project Team Member and Training/Support	Training/Support Target Date	Training/TA Provider	Role	Credentials	06/30/17 Progress	06/30/18 Progress	12/31/18 Progress	6/30/19 Progress
I. Increase core competencies of CTI team to meet program fidelity								
A. CTI team members engage in training provided by [redacted] to build knowledge and skills for CTI program fidelity								
B. CTI team members engage in multi-disciplinary core team training opportunities to increase knowledge and skills necessary to support their work in CTI	March - December 2018							
B1. Team members participate in HIPAA, Secure Data Sharing and 42 CFR Part 2 training	By December 2018							
B1a. HIPAA and Secure Data Sharing training	March 19 and 30, 2018	SNHHS Compliance Staff			N/A	Progress not met training held, but no members of the CTI team participated. More training opportunities will be available by the end of 2018.	Not Achieved	All staff are trained at hire and annually on these topics by GNMH's Director of Quality and Corporate Compliance
Julia T. (.2 FTE)								Y at GNMH
Ashley M. (1 FTE)								Y at GNMH
Ian O. (1 FTE)								Y at GNMH
Kelsey L. (1 FTE)								Y at GNMH
B1b. 42 CFR Part 2 and PHI Sensitive Information Sharing training	expected to be provided by the end of December 2018	TBD			N/A	N/A	Not Achieved	All staff were trained by GNMH Director of Quality and Corporate Compliance upon hire and at least annually thereafter
Julia T. (.2 FTE)								Y at GNMH
Ashley M. (1 FTE)								Y at GNMH
Ian O. (1 FTE)								Y at GNMH
Kelsey L. (1 FTE)								Y at GNMH
B2. Team members participate in use of IDN HIT platforms to support information sharing for care coordination	By December 2018							
B2a. [redacted] Manual Data Portal training	January 4 and 8, 2018	[redacted]			N/A	Progress not met training held, but no members of the team participated. More training opportunities will be available by the end of 2018.	Not Applicable	
B2b. [redacted] Event Notification and Shared Care Plan training	expected to be provided by the end of December 2018	[redacted]			N/A	N/A	Not Achieved	All staff trained on ENS & DSM in April; will be trained on SCP once it is operationalized
Julia T. (.2 FTE)								
Ashley M. (1 FTE)								
Ian O. (1 FTE)								
Kelsey L. (1 FTE)								
B2c. [redacted] Direct Secure Messaging training	expected to be provided by [illegible]	[redacted]			N/A	N/A	Not Achieved	All staff trained on ENS and DSM in April
Julia T. (.2 FTE)								Y
Ashley M. (1 FTE)								Y
Ian O. (1 FTE)								Y
Kelsey L. (1 FTE)								
B3. Team members participate in multi-disciplinary core team (MDCT) training in universal screening	By June 30, 2018							
B3a. DH CCSA and social determinants of health pathways learning session	March 19, 2018	Dartmouth Hitchcock			N/A	Progress met 1 member of the CTI team participated in the training.	Achieved	
B3b. Engaging Community Partners in Addressing Social Determinants of Health	May 16, 2018	Myers and Stauffer/DHHS			N/A	Progress met 1 member of the CTI team participated in the training.	Achieved	
B3c. CCSA tool and IDN protocols and guidelines	expected to be provided by the end of December 2018	IDN			N/A	N/A	Not Achieved	All staff have been trained on the CCSA tool and process used within GNMH
Julia T. (.2 FTE)								Y
Ashley M. (1 FTE)								Y
Ian O. (1 FTE)								Y
Kelsey L. (1 FTE)								Y
B4. Team members participate in multi-disciplinary core team (MDCT) training in cultural competency and adaptation	By June 30, 2018							
B4a. Unpacking Assumptions	March 23, 2018	Ascentria Care Alliance			N/A	Progress met 1 CTI member attended training.	Not Achieved	In progress; will schedule training event to achieve completion
Nancy G. (1 FTE)			CTI Team Coordinator	MS		N		
Ashley M. (1 FTE)			CTI Case Manager	BSW		N		
Ian O. (1 FTE)			CTI Case Manager	BA		N		
Julia T.			GNMHC CTI Team Supervisor	MBA, LCMHC		Y		
Kelsey L. (1 FTE)								
B4b. Stigma Across Cultures	May 3, 2018	Ascentria Care Alliance			N/A	Progress met 1 CTI member attended training.	Achieved	
Nancy G. (1 FTE)			CTI Team Coordinator	MS		Y		
Ashley M. (1 FTE)			CTI Case Manager	BSW		N		
Ian O. (1 FTE)			CTI Case Manager	BA		N		
Julia T.			GNMHC CTI Team Supervisor	MBA, LCMHC		N		
Kelsey L. (1 FTE)								
B5. Team members participate in multi-disciplinary core team (MDCT) training in care planning and care coordination	By December 31, 2018						Achieved	
B5a. CTI Staff training with [redacted]	March 19-20, 2018	[redacted]			N/A	Progress met 1 CTI team member attended the 2-day training.	Achieved	
B6. Team members participate in multi-disciplinary core team (MDCT) training in co-occurring disorders	By December 31, 2018						Not Achieved progress made w/2 attendance at BH Summit Co-Occurring Disorder trainings	All MH awareness training by IDN2
B6a. Co-occurring Disorders (Medical and Behavioral Health Conditions)	expected to be completed by end of 2018	TBD			N/A	N/A	Not Achieved progress made w/2 attendance at BH Summit Co-Occurring Disorder trainings	March - Intersection of chronic illness and BH
Julia T. (.2 FTE)								Y
Ashley M. (1 FTE)								Y
Ian O. (1 FTE)								Y
Kelsey L. (1 FTE)								N/A not employed at time
B6b. Co-occurring Disorders (SUD and Mental Health Conditions)	expected to be completed by end of 2018	TBD			N/A	N/A	Not Achieved progress made w/2 attendance at BH Summit Co-Occurring Disorder trainings	Introduction to Addiction and Recovery Training 3/2018; All staff Narcan Trained this period; All 3 specialists certified in MHFA
Julia T. (.2 FTE)								
Ashley M. (1 FTE)								Y
Ian O. (1 FTE)								Y
Kelsey L. (1 FTE)								Y
C. CTI team members engage in training and educational opportunities to build their core competencies								
C1. Team members participate in Motivational Interviewing training	By June 30, 2018							
C1a. Motivational Interviewing 2-day session	March 26 and April 2, 2018	Peter Fifield			N/A	Progress met 4 CTI team members attended both days of training.	Achieved	
C1b. Advanced Motivational Interviewing 1-day session	July 30 2018	Peter Fifield			N/A	N/A		Achieved
Nancy G. (1 FTE)			CTI Team Coordinator	MS				
Ashley M. (1 FTE)			CTI Case Manager	BSW				
Ian O. (1 FTE)			CTI Case Manager	BA				
Julia T.			GNMHC CTI Team Supervisor	MBA, LCMHC				
D. CTI team members engage in Community of Practice (CoP) provided by [redacted] in collaboration with 4 other IDN regions implementing CTI strategy								
Monthly CoP (2017)								
Monthly CoP (2018)								
Monthly CoP (2019)								
January (in-person)	January 17, 2019							
February	February 27 2019							Y
March	March 27, 2019							Y
April (in-person)	April 24, 2019							Y
May	May 22 2019							Y
June	June 19, 2019							Y
July (in-person)	July 24, 2019							
August	August 28 2019							
September	September 25,2019							
October (in-person)								
November	November 27, 2019							
December	December 25 2019							

E. CTI team members engage in 1:1 technical assistance/implementation coaching with [redacted] to support fidelity assessment and action plan, as well as support implementation challenges/barriers (up to 10 hours annually)								
2018								
2019								
Increase sustainability of CTI Model								
A. CTI team sends a minimum of 1 member to the CTI Train-the-Trainer training								

CTI SUPERVISION

Presented by:
Janice Bainbridge
MSW LCSW

Center for the Advancement of
Critical Time Intervention

SILBERMAN SCHOOL
of SOCIAL WORK
HUNTER COLLEGE | CUNY

WELCOME AND INTRODUCTIONS

- Who are we?
- What do we do?
- Questions for the day?

TOPICS COVERED

- CTI overview
- Clinical supervision: CTI worker competencies and therapeutic skills
  - Relationship and engagement
  - CTI Case management skills
  - Community collaboration
  - Confidentiality and HIPPA
  - Families and social supports
- CTI Fidelity
- CTI team meeting and group supervision
- Individual supervision
- Administrative supervision
- Providing feedback
- Troubleshooting and typical problems
- Burnout prevention

WHAT IS CTI

- An evidenced based service delivery model
- Designed to help people through a ‘Critical’ transition
- A time limited intervention implemented during a critical time period
- Implemented by case managers who work in the communities where people live.
- Aims to improve stability and well-being, continuity of care and community integration by securely linking people to networks of support.

FROM CACTI

- “Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society’s most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods. CTI has been applied with veterans, people with mental illness, people who have been homeless or in prison, and many other groups. The model has been widely used on four continents.” (Center for the Advancement of CTI, 2016)

WHY CTI

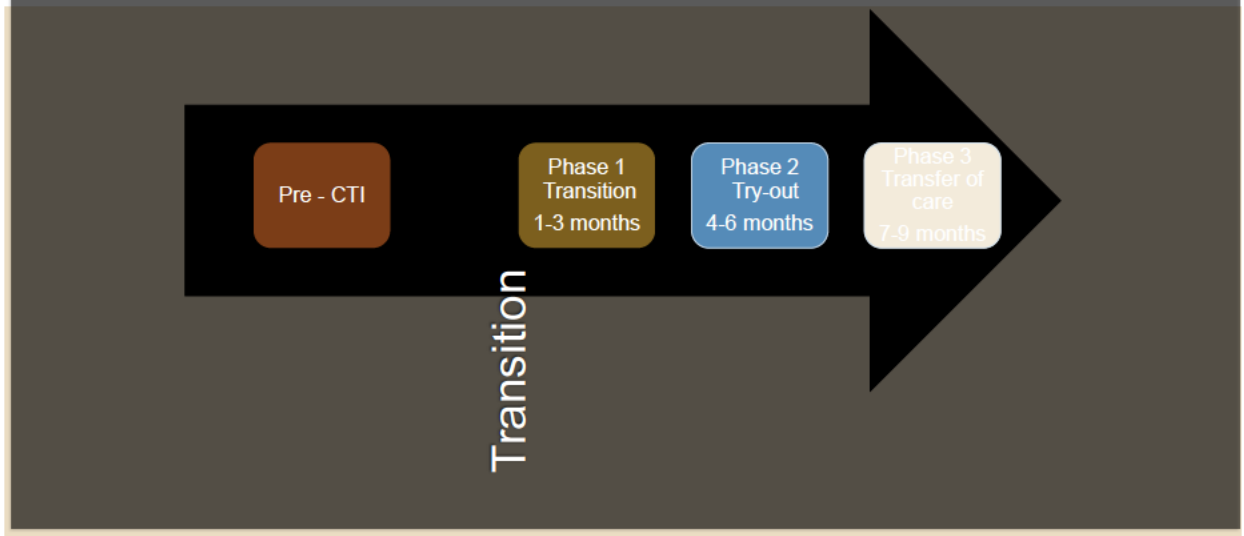
The challenges facing individuals in Critical Transitions can be overwhelming:

- A complex interaction of biopsychosocial needs have resulted in people being vulnerable during transitions
- Social connections are frequently lacking or 'thin'
- Service system navigation is confusing and difficult
- Appropriate resources are limited
- Traditional service models frequently are not responsive to this need set

HOW CTI OFFERS A SOLUTION

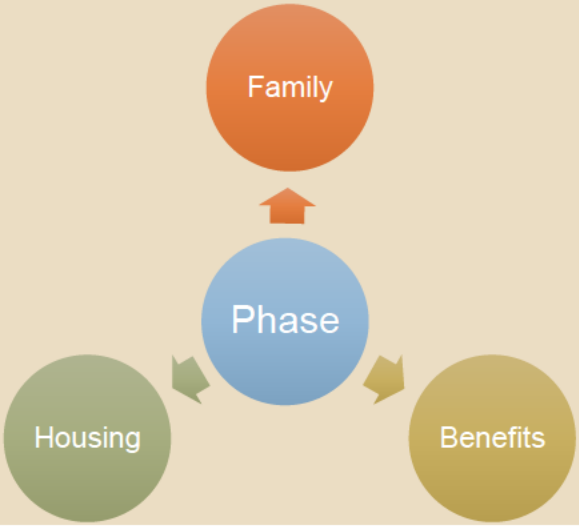
- CTI Principles and Program constructs are *laser focused* on the specific needs of the individual
- Assertive outreach and rapid engagement
- CTI is 'Client Friendly' with engagement strategies and needs that are complimentary to the population served.
- It works: CTI has a substantial and growing evidenced based foundation

CTI COMPONENT OVERVIEW

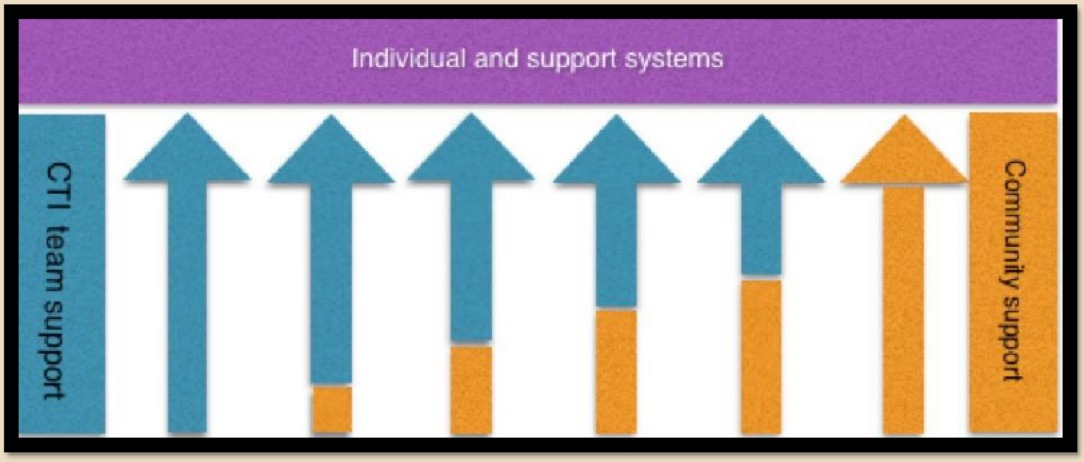


UNFOCUSED

CTI COMPONENTS: FOCUSED



DECREASING INTENSITY



3 PHASES, 9 MONTHS

- Pre-CTI: Initiate relationship
- Phase One: Transition to community/or care
  - Frequent contact
  - Community based (office as indicated by need)
- Phase Two: Tryout
  - Less frequent contact
  - Connection to providers and natural supports are bolstered
  - Problem solving as needed
- Phase Three: Transfer of Care
  - Fewer contacts
  - Monitor and support as needed
  - Termination

TEAM STRUCTURE AND ROLES

CTI TEAM ROLES

1. CTI worker (flexible qualifications)
2. Field Coordinator (flexible qualifications)
3. Clinical Supervisor (Licensed professional)

Clinical supervisor and Field Coordinator can be combined into one licensed position

FIELDWORK COORDINATOR

- Sets up a system for communication in the community
- Provides ongoing assistance in the community
- Ensures that CTI workers carry out tasks from team meetings
Monitors CTI worker progress notes
- Provides updates to clinical supervisor
- Facilitates weekly caseload meetings (or clinical supervisor)
- Coordinates schedules and administrative tasks

CTI WORKER

- CTI is a team approach, but there is one CTI worker for each client.
- Build relationship
- Assess needs
- Responsible for phase planning
- Actively involved in the linking process and addressing goals and problem areasCollaborates with community resources
- Helps person identify and strengthen community connections
  - Existing/ future
  - Informal/ formal
- Monitors community support network

CLINICAL SUPERVISOR

- Holds a clinical degree and is a licensed professional
- Provides clinical perspective and objectivity
- Reinforces collaborative work with client and community
- Help identify high priority clients
- Assist in risk assessment and safety concerns
- May facilitate team meetings
- Ultimately responsible for fidelity

PATH OF THE CLIENT

From engagement to graduation

CTI BEGINNING TO END

- Referral
- Outreach
- Engagement
- Assessment
- Service planning
- Phases
- Discharge/Transition

PRE-CTI

- Rapid engagement: Begin outreach as soon as possible
- Arrange for “meet and greets”
- Go to where the client feels safe and comfortable
- May need to gradually establish trust
- Plan next steps/next visit/how to stay in touch.

OUTREACH AND ENGAGMENT

- Avoid use of jargon and acronyms
- Explain CTI service and what it offers
- Find out what is important to the client
- Complete case management assessment
- Remember that the clock is ticking when Phase 1 starts!

Solve some easy problems right away – this can go a long way for engagement

ENGAGEMENT AND RELATIONSHIP BUILDING

- Be authentic
- Be clear about your role, what you can do and what you can't do (Boundaries)
- Be easy to reach and stay in touch
- Work together in a partnership: "We" talk
- Test ability to give feedback
- Invite feedback yourself

People run out of energy for coping. They need some company in their struggles.

ASSESSMENT OF NEEDS

- Explain the assessment
- Respect a person's narrative/ let a person decline to answer a question
- If you see problems that have an easy solution, highlight that right away
- Validate stress (everyone can relate to stress)
- Convey optimism and hope balanced with realism

PHASE PLANNING

- Ongoing assessment
- New goals at Phases 2 and 3
- Summarize progress toward goals at end of each phase
- Maintain relationship/encouraging new relationships
- Linking, strengthening and monitoring important connections
- Solve problems

Phase One

Transition

Implement transition plan while providing emotional support

PHASE ONE ACTIVITIES

- Home visits
- Assess clinical and environmental needs
- "Introduce" consumers to providers
- Meet with caregivers
- Substitute for caregivers
- Help negotiate ground-rules for relationships
- Mediate conflicts
- Assess potential of support system

Phase Two

Try-Out

Facilitate and test consumer's problem-solving skills
&
capacity of the support system

PHASE TWO ACTIVITIES

- Monitor effectiveness of support system
- Is the fit good?
- Modify as necessary
- Less frequent meetings
- Crisis intervention and troubleshooting

Phase Three

Transfer of Care

Phase 1

Terminate CTI services with support network safely in place

PHASE THREE ACTIVITIES

- Consultation but little direct service
- Ensure key caregivers meet and agree on long-term support system
- Formally recognize end of intervention and relationship

DISCHARGE PLANNING

- During Phase 3 plan for final transfer of care and discharge from CTI program
- Talk with client about discharge from CTI
- Ensure connection to support network
- Let everyone know end date for CTI
- Resolve any lingering problems

DISCHARGE PLANNING/GRADUATION

- During Phase 3 plan for final transfer of care and discharge from CTI program
- Talk with client about discharge from CTI
- Ensure connection to support network
- Let everyone know end date for CTI
- Resolve any lingering problems
- Final meeting with supports and client
- Final meeting with client alone
- Celebration

UNEXPECTED DISENGAGEMENT

- Talk with team:
  - Are they lost or gone for good?
  - Circumstances changed?
  - Have we done all that we could do?
  - Why have they refused?
  - Alternative approaches?
  - How long should we wait?

WHAT'S IN YOUR CTI TOOL BOX

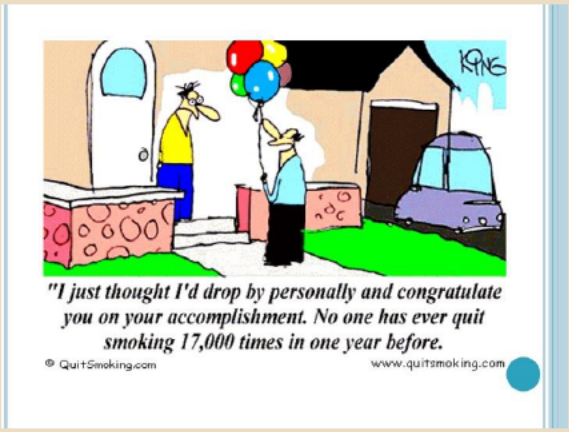
Strategies and Skills

CTI PRINCIPLES

- Housing first
- Motivational Interviewing
- Shared decision-making
- Recovery orientation
- Harm Reduction
- Relationship based
- Trauma informed

MOTIVATIONAL INTERVIEWING

MOTIVATIONAL INTERVIEWING



Life View Without Recovery Focus

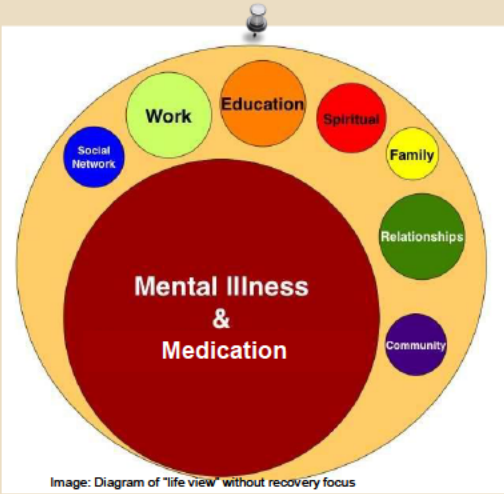


Image: Diagram of "life view" without recovery focus

Life View With Recovery Focus

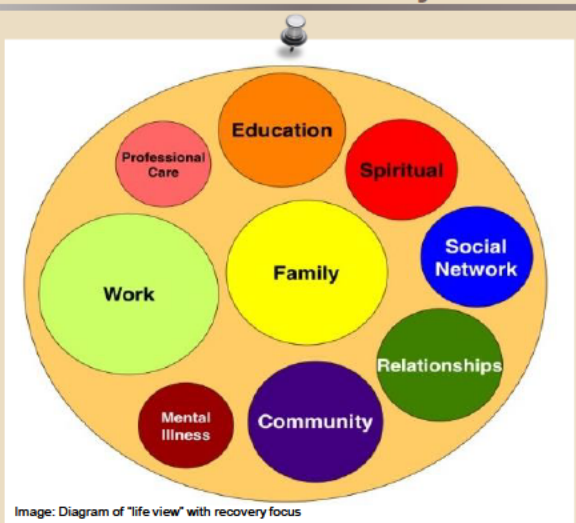


Image: Diagram of "life view" with recovery focus

RELATIONSHIPS

RELATIONSHIP

- A positive working relationship is the most important predictor of success in any evidenced based practice
- CTI workers in the field will have, in some ways, a more casual relationship than an office based worker. They'll be in the car together, drinking coffee, sitting in waiting rooms, dealing with both the mundane, as well as with emergencies.
- **AND…**
- The CTI worker will maintain a professional stance

MAINTAINING RELATIONSHIP OVER TIME

- ‘Validation
- Be easy to reach, stay in touch
- Be clear about what you can do, and cannot do
- Maintain consistent boundaries (this doesn’t mean throw flexibility out the window)
- Ongoing assessment
- Test ability to give feedback
- Invite feedback yourself
- “We” talk. It’s a partnership.

MATH PROBLEM OR SUNSET

$$
\begin{array}{r}
x+(-6+6c) \\
x-c+1\,\overline{)\,x^2-5x+5cx-6b^2} \\
\underline{x^2+x-cx} \\
x(-6+6c)-6b^2 \\
\underline{x(-6+6c)-c(-6+6c)+(-6+6c)} \\
-6b^2+c(-6+6c)-(-6+6c)
\end{array}
$$

CASE MANAGEMENT: LEVELS OF INTENSITY

CTI CASE MANAGEMENT & ENVIRONMENTAL INTERVENTIONS: OVERVIEW

- Encourage/respect independence
- Levels of need vary over time, not always linear
- During engagement err on the side of providing more support
- Increase support during times of stress
- When the outcome is very important, provide more support and intervene more directly
- CTI phase factors: overall goal is to transfer support to others as CTI goes on. Ongoing assessment of support needs for after CTI

CTI CASE MANAGEMENT LEVEL 1: SUPPORT ALREADY EXISTING CAPABILITIES

- Look for and notice areas of strength
- Reinforce/compliment
- Help client to see these personal strengths skills for themselves
- Build on these skills/identity in intentional manner

CIT CASE MANAGEMENT LEVEL 2: COACHING AND GUIDANCE

- Provide information and instructions
  - When, where, who, how, etc.
- Use anticipatory guidance
- Role play or run through “what ifs”
- Best and worst case scenarios
- Problem solving strategies
  - Pros and cons, list all steps involved
- Check to see what worked or did not work

CTI CASE MANAGEMENT LEVEL 3
"DO WITH" THE CLIENT…ACCOMPANIMENT

- Go to appointments
- Make phone calls together
- Fill out applications together
- Read medication instructions
- Consider options and solve problems
- Tasks that require building of independent living skills
- Cultivate an attitude of learning together

CTI CASE MANAGEMENT LEVEL 4:
"DO FOR" THE CLIENT

- Make appointments
- Fill out applications
- Pick up medications
- Access emergency resources
- Transportation
- Advocacy

WHICH LEVEL OF INTENSITY TO USE?

- In general, it is always preferable to provide the least amount of direct support necessary to enhance the client's independence, efficacy, and success.

HOWEVER:

- It's also important to weigh relevant factors:
  - Client motivations
  - Client capabilities, or personal efficacy
  - Severity of needs, especially those needs that are 'high stake'

ASSESS FACTORS THAT AFFECT MOTIVATION

- Negative symptoms of psychosis → lack of volition
- Depressive symptoms → hopelessness and decreased energy
- Anxiety symptoms → worry, fear, avoidance
- Confusion, frustration, anger, or intimidation with 'system'
- Previous negative experiences
- Ambivalence
- Shame about illness and life circumstances
- Family, individual or cultural beliefs regarding accepting help

ASSESS CAPABILITY FACTORS

- Practical barriers: they don't have a way to do something
  - Transportation, financial resources, phone access, no calendar, no internet, lack of support system, lack of knowledge
- Client specific barriers:
  - Symptoms, interpersonal skills, other skills, literacy, medical/physical factors, emotionally dysregulated, confusion
- Check for 'apparent' capabilities vs. 'actual' capabilities
  - May appear willing and capable, but tasks don't get completed for various reasons. Clients can overestimate their own skills, or hide deficits
  - Sometimes it is worth increasing case management support even if it seems a client "should" be able to do something.

CONVENTIONAL VS CTI APPROACH

"I'll only work as hard as my client does"

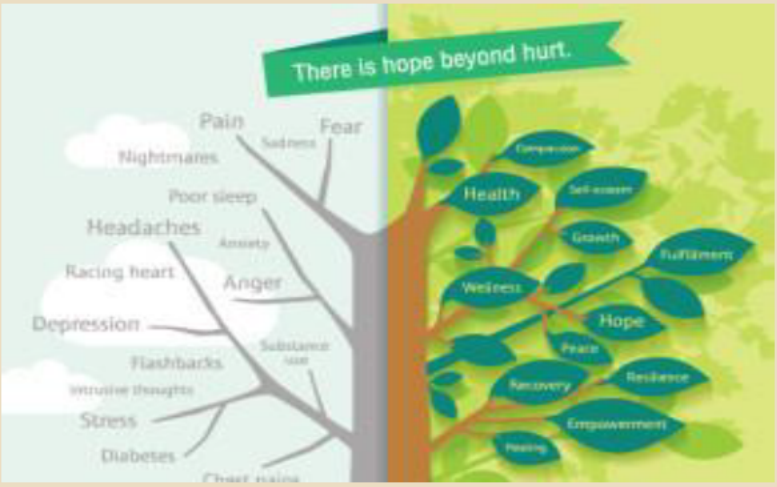
- Adhering rigidly to this conventional approach is Anti-CTI
- During phase one, provide more support
- If the outcome is really important, provide more support, intervene more directly.

EFFECTIVE THERAPEUTIC STRATEGIES

PSYCHO-EDUCATION

- Community resources
- Psychiatric disorders
- Medical concerns and medications
- Lease and tenant requirements
- Shelter policies
- Benefits
- Role modeling
- Translating documents and provide written information
- YouTube

TRAUMA INFORMED CARE



EXPOSURE TO TRAUMA

- People with mental health disorders are more likely to have experienced traumatic events or abuse
- People who are homeless are more likely to have experienced traumatic events or abuse
- Homelessness itself creates vulnerability to exploitation, traumatic events, abuse and violence

RESPONSES TO TRAUMA

- Post Traumatic Stress Disorder
- Acute stress disorder
- Co-occurring substance use disorders
- Personality disorders
- Other health problems
- Often don't feel safe anywhere
- Often don't trust others
- In survival mode, with flight, fight or freeze reactions to various situations

CHALLENGES

- Often these individuals are in stage 1 of recovery with a need to focus on safety and stability
- May be interpersonally challenging
- May have burned bridges or have few supports
- May still be connected to people who have abused them
- Emotionally and behaviorally dysregulated or unstable
- Can be hard to prioritize goals if there are so many problems that feel urgent
- May have frequent crises

HOW TO HELP

- Be trustworthy, consistent, reliable, truthful
- Remember that what they are doing makes sense in some way
- Help them clarify goals
- Connect to supportive agencies such as IPV services
- Know how to tell the difference between a crisis and a life problem

HOW TO HELP

Help the person:

- Engage in self-care strategies
- Build a schedule
- Use some coping skills
- Communicate effectively
- Learn how to keep themselves safe

SKILL BUILDING

- Coping with stress
- Skills in navigating service system
- Interpersonal and communication skills
- Problem solving (break down into steps, pros and cons)
- Self care and management
- Managing difficult emotions
- Recovery skills/WRAP/IMR
- CBT

Keep it real. None of us change fast or easily

CHANGING MALADAPTIVE BEHAVIORS AND BUILDING SKILLS

BEHAVIORAL STRATEGIES

Behavioral Principles apply to all of us: they're universal

- Behaviors that are reinforced are more likely to occur again
- Reminder from Psychology 101:
  - Positive Reinforcement
  - Negative Reinforcement
  - Aversive Consequences (punishment)
  - Shaping
  - Conditioning (classical and operant)

UNDERSTANDING REINFORCEMENT IN ENVIRONMENTS

- People do things because they work in some way.
- Ask:
  - How is this working for them?
  - What is reinforcing their patterns of ineffective coping or unhelpful behaviors?
  - What is reinforcing helpful effective actions?
- Short term vs. long term goals and outcomes often differ
- Examples:

  Drinking provides social support, avoidance diminishes anxiety, not trying something new prevents risk of failing, not rocking the boat in family

CHANGING REINFORCEMENT PATTERNS

- Learn a new skill that works
- Trying something new with positive outcome
- Accumulate experiences that help solidify new habits (have to do things repeatedly to learn)
- Connecting actions explicitly to goals
- Discuss short term goals/outcomes vs. long term goals/outcomes.
- Structure the environment to be reinforcing and supportive of efforts
- Break things down into small steps (shaping)

WORKING WITH OTHERS

COMMUNITY COLLABORATION

Make this easy for others

- Stay in touch with everyone on the team – the CTI worker may be the only one doing this
- Be supportive of others; they also have hard jobs
- Cases can unfold in surprising ways, so keep communicating
- Manage transitions well (Obviously huge ongoing focus of CTI) Overlap, ensuring effective and sustained linking
- Sweat the details- the details matter
- Don't play the "blame game"

ROLE OF CTI WORKER WITH PROVIDERS

- Sharing observations in the field
  - Functioning
  - Ability to manage symptoms and distress
  - Intensity of suffering
- Relationship to psychiatrist enhanced
- Assist in monitoring
- Problem solving (med boxes, schedules etc.)
- Educator: reinforce information provided by psychiatrist
- Advocacy: describe problems, help client communicate to psychiatrist
- Respect wishes to decline medications AND keep conversation going

CONFIDENTIALITY AND HIPPA

- Why talk about this?
- Working with multiple individuals and agencies makes deciding what to share an ongoing process
- Factors to consider about when and what to share, even with release of information consent
  - Client has given explicit permission, or explicit denial
  - Needed for role function
  - Needed to improve care
  - Needed to refer for services
  - Watch for drift into too much disclosing
  - Risk management issues

FAMILY AND SOCIAL SUPPORTS: WHY IT MATTERS

- Nurturance, reassurance, affirmation
- Promotion of hope
- Communication with social world
- Guidance
- Material help and tangible assistance
- Mobilization of supports in a crisis
- Crisis support
- Reminder of personal identity
- Increase health and well-being
- Reality confirmation

FAMILY AND SOCIAL SUPPORT: WHO

- Friends
- Work relationships
- Neighbors
- Church
- Family of origin
- Extended family
- Acquired family
- Community members, social world
- Formal supports
- Club house, senior centers, day programs, groups

FAMILY SUPPORTS: CHALLENGES

- Clients may not give consent, when it seems important to the worker
- Clients may live with family members, and have difficulty getting any privacy, or feel micro-managed
- Family members:
  - Are important for clients overall well-being, and can also be sources of emotional pain or dysfunction
  - may be estranged or disengaged
  - may be frustrated, angry, have unrealistic expectations, blame the client, or blame the worker.
  - may feel burdened, have caregiver fatigue
  - may feel isolated or rejected by others as a result of client illness
  - have their own problems
  - may worry about who will take care of the client after they cannot

FAMILY SUPPORT: WAYS TO HELP

- Don't always need to involve family, not always indicated
- CTI workers need to be able to take a little heat, and not be defensive
- Provide resources and information
- Provide emotional support
- Stay focused on client needs, keep boundary and role clear
- Attend to the specific difficulties: different issues for parents of person with mental illness than for child of person with mental illness
- Be careful to not try to replace family functions
- Focus on strengths

SUPERVISION OF TEAMS AND INDIVIDUAL STAFF

SUPERVISION OBJECTIVES

:

- Ensure that the requirements of CTI are met
- CTI principles are utilized and adhered to
- Relationships with clients are productive and positive
- Problems are addressed
- Therapeutic strategies and skills are appropriately used
- Team functions well and workers feel supported
- Services provided stay within CTI service definition

TEAM SUPERVISION OBJECTIVES

- CTI fidelity
- Team building
- Collaboration
- Create culture
- Mutual support
- Resource sharing

CTI TEAM MEETINGS

CTI TEAM MEETINGS AND GROUP SUPERVISION

Structure of team meeting

- Announcements and administrative issues
- Review referrals
- Review cases
- Collect data
- Clinical decision making
- Team support and development

TEAM MEETING ELEMENTS FOR MODEL FIDELITY

- Fill out required forms (or alternative such as spreadsheet)
- Review all new referrals and assign worker
- Review all cases at least once a month
- Present new cases
- Group supervision for specific issues (outlined on group supervision form):
  - Problem with support system
  - Crisis
  - Lost or disengaged or refusing services
  - Significant event or big change of some kind
  - Plan for new intervention or phase
  - Good news
  - Upcoming discharge

PRINCIPLES OF GROUP SUPERVISION

- Overall principles:
  - Stay focused on supporting team in problem solving, NOT negativity and blame of clients (limits of venting)
  - Serving clients effectively is primary goal
  - Culture of openness and vulnerability about difficulties *and* listening to feedback and suggestions
  - Supervisors should create a sense of safety and trust

This is difficult work and everyone can get discouraged, stuck or lost

DATA COLLECTION AND DOCUMENTATION

- Phase date form
- Case review form
- Group supervision form
- Agency specific forms
- Progress notes
- Phase plans

A spreadsheet might be used to consolidate some of this information

TYPICAL CLINICAL ISSUES

- Difficulty engaging client
- Interventions not effective
- Lack of needed resources
- Relapses and hospitalizations
- New legal problems
- Crisis: (legal problems, imminent eviction etc.)
- Relationship disruption
- Difficulty prioritizing work due to multiple problem areas
- Boundary issues
- Risk assessment concerns
- Termination of CTI

PROBLEMS THAT CAN DERAIL CTI

- Disconnect between client goals and CTI workers goals
- Phases have become ‘muddy’
- Termination difficulties
- Relationship problems that may include ‘not liking’, safety concerns, or incompatibility of some kind
- CTI drifting off course: starts to look like routine case management or some other service
- Limits of CTI, limits of CTI Worker
- Other problems?

INDIVIDUAL SUPERVISION

TASKS OF INDIVIDUAL SUPERVISION

- Regular meeting time, but be available at other times
- Documentation and productivity monitoring
- Coach, teach, mentor
- Offer clinical perspective
- Promote self reflection
- Provide positive feedback
- Provide corrective feedback when needed
- Promote quality program
- Observe work if possible

POSITIVE SUPERVISION STRATEGIES

- Acceptance of different styles and personalities
- Value person's inherent worth and potential and autonomy
- Emphasize this is an opportunity for the person to get support for their work.
- Make a point to acknowledge good work
- Positivity ratio
- Elicit person's own knowledge, experience and motivation
- Encourage openness and questions
- Role model accepting feedback and being imperfect
- Care about person's professional goals
- Recognize that many things are areas of growth over time
- Affirm Strengths and skills

"DONT'S" OF INDIVIDUAL SUPERVISION

DON'T

- Use supervision time to just talk about yourself
- Nit pick or focus on small details that don't matter much
- Overload (Trying to take a sip from a firehose)
- Underload (assuming they won't understand or don't need to know)
- Withhold information that would be helpful in their job
- Compare to others
- Talk in a demeaning way about clients or other staff
- Avoid talking about something difficult
- Talk more than you listen

GIVING FEEDBACK

HOW TO ADDRESS A CONCERN

- Find a good time and place
- Report factually what you have observed, or what happened
- Convey thoughts or questions you had about it
- Express your concerns
- Potential impact on client care, agency or other areas of service
- Emphasize how this is connected to being an effective program.

HOW TO ADDRESS A CONCERN

- Ask for supervisee perspective, seek to understand
- Validate whatever you can. There is something that is understandable about their actions.
- Be aware that emotions are involved, on both sides
- Be open to clarifying your own misunderstandings
- Aim for a mutual understanding

HOW TO ADDRESS A CONCERN

- Clear plan moving forward
- Don't expect perfection, just progress
- Stay in touch about it, note progress
- If something is an "absolute must" say so clearly
- Tell them they are important to the program and you are invested in them as employees
- End on a positive note

SMALL GROUP EXERCISE ON FEEDBACK

- Role play giving feedback about one of the following scenarios
  - A CTI worker is overheard having a conversation with a community provider in which she became angry and was sharp and demanding
  - CTI worker is disengaging from client; feels they won't change.
  - A CTI worker is not completing documentation in a correct or timely manner
- Discussion about observations

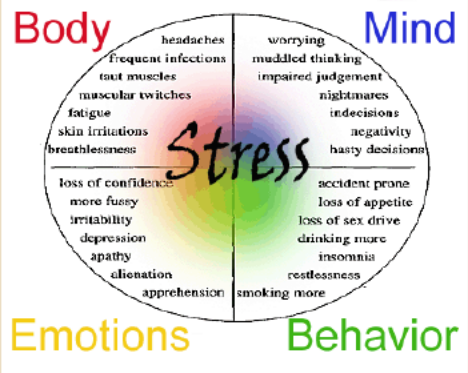
ADMINISTRATIVE SUPERVISION

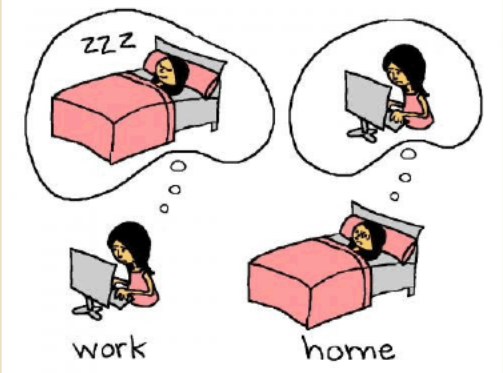
- Hiring and training
- Program oversight
- Model fidelity
- Productivity
- Communication (top down and bottom up)
- Documentation compliance
- Agency policies
- Scheduling

MORALE BUILDING

- Get together as a team for fun
- Offer desired training
- Respecting time off and personal needs
- Act as an advocate for your team
- Be a link for communication within your agency
- New responsibilities that are appealing
- Listen to workers ideas, validate their expertise, give them input where possible
- Pay raises or other compensation

BURNOUT AND STRESS





QUESTIONS AND COMMENTS

YOU ALL ARE AMAZING!!!

Projects D: Capacity-Focused

attachment_D.1a: IDN Community Project: Implementation Plan
attachment_D.9a: IDN Community Project Training Plan

Status	Task Name	Comments
Complete	Stage 1: Project Planning and Process Milestones (Development of Implementation Plan) January to June 2017	
Complete	Stage 1: Project Planning and Process Milestones (Design/Develop Clinical Services Infrastructure) January to June 2017	
Complete	I. Develop/Identify Standardized Assessment Tools	
Complete	A. Work with project strategy partners to document the assessments currently used	
Complete	B. Work with project strategy partners to identify potential assessments to be used	
Complete	II. Develop/Identify Patient Assessment, Treatment, Management and Referral Protocols	
Complete	A. Work with project strategy partners to document protocols currently in place	
Complete	A1. Youth SUD Services in Schools	
Complete	A1a. The Youth Council	
Not started	A2. Adult Medical Detox	
Not started	A2a. Harbor Homes	
Not started	A2b. Keystone Hall	
In progress	A3. Adult Community-Based Non-Treatment Groups	
Not started	A3a. GNMHC and HEARTS	
Complete	A3b. The Emmaus Institute	
In progress	A4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	A4a. SNMHC	
Not started	A4b. St. Joseph Hospital and Physician Practices	
Complete	B. Work with project strategy partners to identify potential protocols and workflows to be used	
Complete	B1. Youth SUD Services in Schools	
Complete	B1a. The Youth Council	
Not started	B2. Adult Medical Detox	
Not started	B2a. Harbor Homes	
Not started	B2b. Keystone Hall	
In progress	B3. Adult Community-Based Non-Treatment Groups	
Not started	B3a. GNMHC and HEARTS	
Complete	B3b. The Emmaus Institute	
In progress	B4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	B4a. SNMHC	
Not started	B4b. St. Joseph Hospital and Physician Practices	
In progress	III. Identify/Develop Roles and Responsibilities of Team Members	
In progress	A. Work with program strategy leads to establish roles and responsibilities of team members	
Complete	A1. Youth SUD Services in Schools	
Not started	A2. Adult Medical Detox	
Not started	A2a. Harbor Homes	
Not started	A2b. Keystone Hall	
In progress	A3. Adult Community-Based Non-Treatment Groups	
Not started	A3a. GNMHC and HEARTS	
Complete	A3b. The Emmaus Institute	
In progress	A4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	A4a. SNMHC	
Not started	A4b. St. Joseph Hospital and Physician Practices	
Complete	IV. Identify/Develop Training Plan	
Complete	A. Assess staff training needs of each project strategy	
Complete	B. Create logistics plan for trainings	
Complete	C. Contract with vendors/purchase trainings	
In progress	D. Schedule trainings	
In progress	E. Identify mechanisms for participants to engage in trainings	
In progress	E1. Conduct trainings as a mix of in-person short (breakfast or lunch) and longer (3.5 hours to 8 hours), depending upon the topic. Some training topics are conducive to webinar and/or through voiced-over PowerPoint training formats.	
In progress	V. Develop/Identify Training Curricula	
In progress	A. Work with potential vendors to identify/develop curriculum, develop training format and develop evaluation mechanisms	
In progress	VI. Identify/Develop Agreements with Collaborating Organizations	
In progress	A. Work with IDN Member Entity leadership to execute sub-contracts	
Complete	A1. Youth SUD Services in Schools	
In progress	A2. Adult Medical Detox	
In progress	A2a. Harbor Homes	expected to be executed by September 30, 2018, due to changes in leadership impacting ability to move forward with DN engagement
In progress	A2b. Keystone Hall	expected to be executed by September 30, 2018, due to changes in leadership impacting ability to move forward with DN engagement
In progress	A3. Adult Community-Based Non-Treatment Groups	
Not started	A3a. GNMHC and HEARTS	complete
Complete	A3b. The Emmaus Institute	expected to be executed by July 30, 2018, as relationships were being built with IDN partners to identify sites and potential members
In progress	A4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	A4a. SNMHC	Scope of work has been executed, with continuation of existing SUD Recovery Care Coordinator in place from NH Foundation for Health initial funding, which has lapsed.

In progress	A4b. St. Joseph Hospital and Physician Practices	expected to be executed by September 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership
In progress	VII. Develop evaluation plan, including metrics that will be used to measure program impact	
Complete	A. Middle School Student Assistance Program (Project MPACT) evaluation targets identified	
Not started	B. Adult Medical Detox evaluation targets identified	
Not started	B1. Adult medical detox evaluation targets are identified	
Not started	B2. Adult medical non-detox evaluation targets are identified	
In progress	C. Adult Community-Based Pre-Treatment and Non-Treatment Groups targets identified	
In progress	C1. Spirituality community-based non-treatment group evaluation targets identified	
In progress	C2. Pre-treatment community-based group evaluation targets identified	
In progress	D. SUD/recovery transitional care coordination from Hospital Emergency Departments targets identified	
In progress	C1. SNHMC SUD/recovery care transition evaluation targets identified	
Not started	C2. St. Joseph Hospital SUD/recovery care transition evaluation targets identified	
Complete	VIII. Identify mechanisms (registries) to track and monitor individuals served by the program, adherence, and impact measures.	
In progress	A. Use hard copy spreadsheets and/or organizational EHRs to track and monitor progress and early impacts for the strategies until HIT platforms are in place with IDN protocols and policies identified	
In progress	A1. GNMHC, SNHMC, Harbor Homes, Keystone Hall, and St. Joseph Hospital and Physician Practices will utilize EHR to monitor and track patients and impacts	
In progress	A2. The Emmaus Institute will utilize spreadsheets to track and monitor patients and impacts	
Complete	B. Use of HIT platforms to track and monitor individuals served by strategies	
In progress	Stage 1: Project Planning and Process Milestones (Operationalization of Program) July to December 2017	
In progress	I. Implementation of workforce plan	
In progress	A. Use of DN funds and exposure (where applicable) to recruit and hire/on-board workforce to implement project strategies	
Complete	A1. Middle School Student Assistance Program (Project IMPACT)	
Not started	A2. Adult Medical Detox	
Not started	A2a. Detox RN Case Manager on-boarded	expected to occur by October 30, 2018, due to turnover in leadership across the organization delaying execution of sub-contracts and implementation of strategies
Not started	A2b. Non-Detox RN Case Manager on-boarded	expected to occur by October 30, 2018, due to turnover in leadership across the organization delaying execution of sub-contracts and implementation of strategies
Complete	A3. Spirituality Community-based Non-Treatment Groups	
Complete	A4. Pre-Treatment Community-based Groups	
In progress	A5. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	A5a. SNHMC SUD Recovery Care Coordinator on-boarded	complete
Not started	A5b. Peer Support Specialist on-boarded	expected to be on-barded by September 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership
In progress	II. Deployment of training plan	
In progress	A. Workforce funded in the D3 project engage in training to build core competencies as part of multi-disciplinary core team (MDCT)	
In progress	A1. Patient Privacy/Consent and Secure Data Storage	
In progress	A1a. H PPA and Secure Sharing/Storage of Protected Health Information provided by the IDN Admin Lead	3 members of the D3 IDN-funded workforce participated in this training in March 2018
In progress	A1b. Patient Privacy and Consent re: 42 CFR Part 2	expected to be provided by December 31, 2018
In progress	A2. CCSA and Universal Screening	
In progress	A2a. Dartmouth Hitchcock CCSA and SDOH Pathways Learning Session	3 members of the D3 IDN-funded workforce participated in this learning session in March 2018
Complete	A2b. Engaging Community Partners in Addressing Social Determinants of Health Training provided by DHHS/Myers and Stauffer	2 members of the D3 IDN-funded workforce participated in this learning session in May 2018
In progress	A2c. Use of CCSA process with overview of DN protocols/guidelines	expected to be conducted by December 31, 2018
In progress	A3. Use of HIT platforms (ENS, DSM, SCP) to support information sharing and communication workflows and protocols	
In progress	A3a. Use of [redacted] Data Portal and Patient Dashboard for IDN Data Reporting	3 members of the D3 IDN-funded workforce participated in this learning session in May 2018. We expect to provide additional training on the use of the [redacted] tool by December 31 2018.
In progress	A3b. Use of [redacted] for Event Notification (ENS) and Shared Care Plan (SCP)	expected to be provided by December 31, 2018
In progress	A3c. Use of [redacted] for Direct Secure Messaging (DSM)	expected to be provided by December 31, 2018
In progress	A4. Understanding Addiction and Treating Patients with Co-Occurring Disorders	
Complete	A4a. Initial Training on Addiction, provided by BDAS	5 members of the D3 IDN-funded workforce participated in this training in May 2018.
In progress	A4b. Co-Occurring Disorders (SUD and Mental Health): Staff trained in an overview of co-occurring disorders, including prevalence and screening provided by NH Healthy Families	3 members of the D3 IDN-funded workforce participated in this training in June 2018.
In progress	A4bi. Project MPACT	1 member of the Project IMPACT team was trained
In progress	A4bii. Adult Medical Detox	No members of the Adult Medical Detox strategy participated in this training, which was held in May 2018.
In progress	A4biii. Spirituality Community-based Non-Treatment Groups	1 group facilitator participated in this training.
In progress	A4biv. Pre-Treatment Community-based Groups	No members of the Pre-Treatment Community-based Groups strategy participated in this training, which was held in January 2018.
In progress	A4bv. SUD/recovery transitional care coordination from hospital emergency departments	1 member of the SUD/recovery transitional care coordination strategy participated in this training which was held in January 2018.
In progress	A4c. Co-Occurring Disorders (Medical and Behavioral Health Disorders)	expected to be provided by December 31, 2018

In progress	A4ci. Project IMPACT	expected to be provided by December 31, 2018
In progress	A4cii. Adult Medical Detox	expected to be provided by December 31, 2018
In progress	A4ciii. Spirituality Community-based Non-Treatment Groups	expected to be provided by December 31, 2018
In progress	A4civ. Pre-Treatment Community-based Groups	expected to be provided by December 31, 2018
In progress	A4cv. SUD/recovery transitional care coordination from hospital emergency departments	expected to be provided by December 31, 2018
Complete	A4d. Motivational Interviewing, provided by David Lynde and Christine Powers	3 members of the D3 IDN-funded workforce participated in this training in June 2018.
Complete	A5. Cultural Competency and Adaptation	
In progress	III. Implementation of any required updates to clinical protocols, or other operating policies and procedures	
Complete	A. Student Assistance Program (Project MPACT)	
Not started	B. Adult Medical Detox (Detox and Non-Detox)	
Not started	B1. Expectation to begin enrolling patients by mid-2018, upon execution of sub-contract	expected to occur by October 30, 2018, due to turnover in leadership across the organization delaying execution of sub-contracts and implementation of strategies
In progress	C. Adult Community-Based Pre-Treatment Groups	
In progress	C1. Expectation to begin enrolling group members by end of first quarter of 2018, upon execution of sub-contract	expected to be executed by August 31, 2018, as sub-contracting with H.E A.R.T.S. Peer Support Center is still in process and initial outreach for group participants will begin in July 2018
In progress	D. Adult Community-Based Spirituality Non-Treatment Groups	
In progress	D1. Expectation to begin enrolling group members by end of first quarter of 2018, upon execution of sub-contract	expected to be executed by July 30, 2018, as relationships were being built with IDN partners to identify sites and potential members
Complete	E. SUD Recovery/Transitional Care Case Manager Intervention (SNHMC)	
Complete	E1. Expectation to begin supporting patients in the ED by end of second quarter of 2018, upon execution of sub-contract	Complete, with protocols, policies and procedures in place from pilot of this model through NH Foundation for Health funding. Continued work will be done with IDN Clinical Committee on to finalize DN-specific protocols and guidelines to support data reporting.
Not started	F. SUD Recovery/Transitional Care Case Manager Intervention (St. Joseph Hospital)	
Not started	F1. Expectation to begin supporting patients in the ED by end of first quarter of 2018, upon execution of sub-contract	Expectation for workforce to be on-boarded by September 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership. Dartmouth Hitchcock AmeriCorps VISTA has been engaging in support for this role in the interim with the SJH Emergency Department (Daniel R.) as of April 2018, through funding support from the IDN (A1 project funds)
In progress	IV. Use of assessment, treatment, management and referral protocols	
Complete	A. Student Assistance Program (Project MPACT)	
Not started	B. Adult Medical Detox (Detox and Non-Detox)	
In progress	C. Adult Community-Based Pre-Treatment Groups	
Not started	C1. Meet with facilitators to determine any screening and referral protocols to be implemented	
Not started	C2. Begin outreach to secure potential participants	expected to be conducted in July and early August 2018
Not started	C3. Expectation to begin enrolling group members by end of first quarter of 2018, upon execution of sub-contract	expected to be executed by August 31, 2018, as sub-contracting with H.E A.R.T.S. Peer Support Center is still in process and initial outreach for group participants will begin in July 2018
Complete	D. Adult Community-Based Spirituality Non-Treatment Groups	
Complete	D1. Meet with facilitators to determine any screening and referral protocols to be implemented	
Complete	D2. Begin outreach to secure potential participants, likely hosting initial groups at Revive Recovery Center	Outreach conducted with Revive Recovery Center and United Methodist Church (Nashua)
Complete	D3. Expectation to begin enrolling group members by end of first quarter of 2018, upon execution of sub-contract	Groups slated to begin in July 2018, likely at both locations
Complete	E. SUD Recovery/Transitional Care Case Manager Intervention (SNHMC)	
Complete	E1. Meet with key clinical leaders and HIT staff	
Complete	E2. Finalize HIT platform implementation and clinical workflows with clinical leaders and decision-makers	Expected to be completed by August 15, 2018, but is currently utilizing EHR and other internal tools for workflows and protocols. SNHHS has executed contract with [redacted] for DSM and with [redacted] for [redacted]
Complete	E3. Expectation to begin supporting patients in the ED by end of first quarter of 2018 upon execution of sub-contract	
Not started	F. SUD Recovery/Transitional Care Case Manager Intervention (St. Joseph Hospital)	
Not started	F1. Meet with key clinical leaders and decision-makers	
In progress	F2. Work through HIT platform implementation and clinical workflows with clinical leaders and decision-makers	Expectation to finalize workflows and use of IT platforms by September 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership. Dartmouth Hitchcock AmeriCorps VISTA has been engaging in support for this role in the interim with the SJH Emergency Department (Daniel R.) as of April 2018, through funding support from the IDN (A1 project funds)
Not started	F3. Expectation to begin supporting patients in the ED by end of second quarter of 2018, upon execution of sub-contract	Expectation to begin supporting patients by October 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership. Dartmouth Hitchcock AmeriCorps VISTA has been engaging in support for this role in the interim with the SJH Emergency Department (Daniel R.) as of April 2018, through funding support from the IDN (A1 project funds)
In progress	Stage 2: Project Utilization Milestones (Initiation of Data Reporting) July to December 2017	
In progress	I. Reporting on number of individuals served (during reporting period and cumulative) vs. projected	
Complete	A1. Student Assistance Program (Project IMPACT)	
Not started	A2. Adult Medical Detox (Detox and Non-Detox)	
Not started	A2a. Expectation to begin enrolling patients by mid-2018, upon execution of sub-contract	Expected to execute IDN sub-contract by October 30, 2018 and be enrolling patients by the end of 2018, due to turnover in leadership across the organization delaying execution of sub-contracts and implementation of strategies
In progress	A3. Adult Community-Based Pre-Treatment Groups	
In progress	A3a. Expectation to begin enrolling group members by end of first quarter of 2018, upon execution of sub-contract	Expected to be enrolling group members by August 31, 2018, as sub-contracting with H.E A.R.T.S. Peer Support Center is still in process and initial outreach for group participants will begin in July 2018
In progress	A4. Adult Community-Based Spirituality Non-Treatment Groups	

In progress	A4a. Expectation to begin enrolling group members by end of first quarter of 2018 upon execution of sub-contract	Groups slated to begin in July 2018, likely at both Revive Recovery Center and United Methodist Church (Nashua)
Complete	A5. SUD Recovery/Transitional Care Case Manager Intervention (SNHMC)	
Not started	A6. SUD Recovery/Transitional Care Case Manager Intervention (St. Joseph Hospital)	
Not started	A6a. Expectation to begin supporting patients in the ED by end of first quarter of 2018, upon execution of sub-contract	Expectation to begin supporting patients by October 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership. Dartmouth Hitchcock AmeriCorps VISTA has been engaging in support for this role in the interim with the SJH Emergency Department (Daniel R.) as of April 2018, through funding support from the IDN (A1 project funds)
In progress	II. Reporting on number of staff recruited and trained (during reporting period and cumulative) vs. projected	
In progress	A. Number of staff recruited (during reporting period and cumulative) vs. projected	
Complete	A1. Student Assistance Program in Nashua Middle Schools: 1 Master's Level Counselor recruited vs. 1 projected	
Not started	A2. Adult Medical Detox: 0 staff recruited/on-boarded vs. 2 (1.2 FTEs) projected	expected to occur by October 30, 2018, due to turnover in leadership across the organization delaying execution of sub-contracts and implementation of strategies
Complete	A3. Community-based Non-Treatment Groups: 2 facilitators recruited vs. 3 projected	GNMHC has executed the DN sub-contract, but has not finalized the sub-contracting with H.E.A R.T.S. for co-facilitation role.
In progress	A4. Hospital Emergency Department SUD Transitional Care: 1 recruited/on-boarded (5 FTEs) vs. 2 projected (.5 FTEs)	SNHMC coordinator on-boarded, but St. Joseph Hospital coordinator is expected to be on-boarded by October 2018, due to the health system's migration to a new EHR and leadership turnover.
In progress	B. Number of staff trained (during reporting period and cumulative) vs. projected	
In progress	A1. Patient Privacy/Consent and Secure Data Storage	Training expected in early 2018
In progress	A1a. H PPA and Secure Sharing/Storage of Protected Health Information provided by the IDN Admin Lead	3 members of the D3 IDN-funded workforce participated in this training in March 2018
In progress	A1b. Patient Privacy and Consent re: 42 CFR Part 2	expected to be provided by December 31, 2018
In progress	A2. CCSA and Universal Screening	Training expected in early 2018
Complete	A2a. Dartmouth Hitchcock CCSA and SDOH Pathways Learning Session	3 members of the D3 IDN-funded workforce participated in this learning session in March 2018
Complete	A2b. Engaging Community Partners in Addressing Social Determinants of Health Training provided by DHHS/Myers and Stauffer	2 members of the D3 IDN-funded workforce participated in this learning session in May 2018
In progress	A2c. Use of CCSA process with overview of DN protocols/guidelines	expected to be conducted by December 31, 2018
In progress	A3. Use of HIT platforms (ENS, DSM, SCP) to support information sharing and communication workflows and protocols	Training expected in early 2018
In progress	A3a. Use of [redacted] Data Portal and Patient Dashboard for DN Data Reporting	3 members of the D3 IDN-funded workforce participated in this learning session in May 2018. We expect to provide additional training on the use of the [redacted] tool by December 31 2018.
In progress	A3b. Use of [redacted] for Event Notification (ENS) and Shared Care Plan (SCP)	expected to be provided by December 31, 2018
In progress	A3c. Use of [redacted] for Direct Secure Messaging (DSM)	expected to be provided by December 31, 2018
In progress	A4. Understanding Addiction and Treating Patients with Co-Occurring Disorders	Training expected in early 2018
In progress	A4a. Initial Training on Addiction, provided by BDAS	5 members of the D3 IDN-funded workforce participated in this training in May 2018.
In progress	A4b. Co-Occurring Disorders (SUD and Mental Health): Staff trained in an overview of co-occurring disorders, including prevalence and screening provided by NH Healthy Families	3 members of the D3 IDN-funded workforce participated in this training in June 2018.
In progress	A4c. Co-Occurring Disorders (Medical and Behavioral Health Disorders)	expected to be provided by December 31, 2018
In progress	A4d. Motivational Interviewing, provided by David Lynde and Christine Powers	3 members of the D3 IDN-funded workforce participated in this training in June 2018.
In progress	A5. Cultural Competency and Adaptation	Training expected in early 2018
In progress	A5a. Unpacking Assumptions provided by Ascentria Care Alliance	3 members of the D3 IDN-funded workforce participated in this training in March 2018.
In progress	A5b. Stigma Across Cultures provided by Ascentria Care Alliance	1 members of the D3 IDN-funded workforce participated in this training in May 2018.
In progress	III. Reporting on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	
Complete	A. Up to 9 DN-funded positions in the D3 strategies participate in universal screening training by 12/31/18.	Progress not met: These trainings are currently scheduled for start 2nd Quarter of 2018, engaging all of the D3 positions in their participation.
Complete	B. Up to 9 DN-funded positions in the D3 strategies participate in universal screening training by 12/31/18.	Progress met: DN members participated in the 42 CFR Part 2 boot camps provided by the UNH Law School in June and July 2017. Participation included representatives from Harbor Homes, Keystone Hall, Lamprey Health, HEARTS Peer Support Center, Southern NH Medical Center, Foundation Medical Partners, The Youth Council, St. Joseph Hospital and Physician Practices and the IDN Admin Lead.
Complete	C. Up to 9 IDN-funded positions in the D3 strategies participate in training on communication protocols and workflows (through HIT vendor technologies) by 12/31/18.	Progress met: DN members participated in educational sessions hosted by [redacted] on October 23rd and 26th to provide an overview of the event notification and shared care plan platforms. Future training specific to use in the IDN will be provided in early-mid 2018 as part of the on-boarding process for organizations once IDN sub-contracts and [redacted] Master Service Agreements and Business Associate Agreements are executed.
Complete	D. Up to 4 of the IDN-funded positions in the D3 strategies participate in the ASAM training by 12/31/18.	Progress not met: This training is currently scheduled for GNMHC staff in January 2018, with training available to other D3 member organizations later in 2018.
Complete	E. Up to 10 Primary Care Physicians (PCPs) across the IDN Member provider practices have met with the IDN funded Student Assistance Program Counselors to receive information about SB RT and referral resources by 12/31/18.	Progress met: The Youth Council's Project Impact engaged with primary care providers at Foundation Medical Partners through meetings with 3 of the pediatric practices, as well as sharing information/answering questions at quarterly division meetings of the pediatric and family practices.
Complete	F. Brief intervention/education and assessment services provided by Project IMPACT counselor(s) for up to 60 Nashua Middle School students by the end of the first sub-contracting period (June 30, 2018)	Progress met: 10 youth were screened/assessed through The Youth Council's Project MPACT, the Student Assistance Program being piloted in the Nashua Middle Schools. of those screened/assessed, 3 are awaiting further assessment/treatment with higher levels of support from IDN member providers.
Complete	G. New relationships with up to 5 primary care physician practices through up to 10 presentations to providers to educate them about the services available from Project IMPACT	Progress met: Project IMPACT presentations to FMP at their Quarterly Family Practice meeting (Dec 7, 2017) and Pediatric Practice meeting (Dec 14, 2017)

In progress	H. Treatment provided through medical detox/Medication Assisted Treatment (MAT) to up to 125 patients by the end of the end of the sub-contracting period (June 30, 2018)	Progress not met: The Partnership for Successful Living has had significant turnover in leadership and is evaluating timing and ability to implement strategies within the DN, with the expectation of making decisions in early 2018.
Complete	I. Up to 80 individuals will participate in the community-based pre-treatment groups and/or the spirituality non-treatment groups by the end of the first sub-contracting period (June 30, 2018)	Progress not met: both the GNMHC and Emmaus Institute sub-contracts are in progress, with identification of outreach methods, locations, and tracking/referral protocols, which are expected to be finalized in early 2018.
Complete	J. Up to 125 patients seen in the Emergency Departments at SNHMC and St. Joseph Hospital will participate in screening/assessment and discharge/referral to IDN Member Entity SUD treatment providers by the end of the sub-contracting period (June 30, 2018)	Progress not met: expectation to begin supporting patients by October 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership. Dartmouth Hitchcock AmeriCorps VISTA has been engaging in support for this role in the interim with the SJH Emergency Department (Daniel R.) as of April 2018, through funding support from the IDN (A1 project funds)
Complete	Stage 2: Project Utilization Milestones (Ongoing Data Reporting) January to June 2018	
Complete	I. Number of individuals served (during reporting period and cumulative), vs. projected	54 students screened with S2B1 and 49 followed up with brief supportive counseling in school. 20 students referred for more BH therapy provided by Youth Council and its affiliates.
Complete	A. Student Assistance Program in Nashua Middle Schools: 58 youth served vs. 60 projected	Progress met: 58 middle school youth were referred to Project IMPACT counselors
Not started	B. Adult Medical Detox: 0 served vs. 125 projected	Progress not met: The Partnership for Successful Living is expected to execute IDN sub-contract by October 30, 2018 and be enrolling patients by the end of 2018, due to turnover in leadership across the organization delaying execution of sub-contracts and implementation of strategies.
Complete	C. Community-based non-treatment groups: 0 individuals served vs. 80 projected	In process: Pre-Treatment Groups: GNMHC has executed the IDN sub-contract, but has not finalized the sub-contracting with H.E.A R.T.S. for co-facilitation role. Groups are expected to be running by end of August 2018. Spirituality Non-Treatment Groups: Emmaus has been working with Revive Recovery Center and United Methodist Church (Nashua) to have groups there, beginning in July 2018.
Complete	D. Hospital Emergency Department SUD Transitional Care: 87 screened with 73 referred to additional SUD services vs. 125 projected	In process: SNHMC SUD Recovery Care Coordinator served 87 patients, with 73 being referred for additional services. She has begun to shift her work to addressing the IDN goals, including the use of the [redacted] and [redacted] platforms, once they are in place with workflows (contracts/BAAs have been executed between SNHMC and these vendors). St. Joseph Hospital has received an Americorps VISTA (Daniel R.) through Dartmouth Hitchcock's Community Resource Corps who is working in the ED. Once IDN sub-contracts are executed, more data will be available.
Complete	II. Number of staff recruited and trained (during reporting period and cumulative) vs. projected	
Complete	A. Number of staff recruited (during reporting period and cumulative) vs. projected	
Complete	A1. Student Assistance Program in Nashua Middle Schools: 1 Master's Level Counselor recruited vs. 1 projected	Two Master Level Counselor working on the project during the reporting period. Two interns from Rivier University were hired in June with placement date of October 1st, 2018.
Not started	A2. Adult Medical Detox: 0 staff recruited/on-boarded vs. 2 (1.2 FTEs) projected	expected to occur by October 30, 2018, due to turnover in leadership across the organization delaying execution of sub-contracts and implementation of strategies
Complete	A3. Community-based Non-Treatment Groups: 2 facilitators recruited vs. 3 projected	GNMHC has executed the DN sub-contract, but has not finalized the sub-contracting with H.E.A R.T.S. for co-facilitation role.
Complete	A4. Hospital Emergency Department SUD Transitional Care: 1 recruited/on-boarded (5 FTEs) vs. 2 projected (.5 FTEs)	SNHMC coordinator on-boarded, but St. Joseph Hospital coordinator is expected to be on-boarded by October 2018, due to the health system's migration to a new EHR and leadership turnover.
In progress	B. Number of staff trained (during reporting period and cumulative) vs. projected	
Complete	B1. Patient Privacy/Consent and Secure Data Storage	
Complete	B1a. H PPA and Secure Sharing/Storage of Protected Health Information provided by the IDN Admin Lead: 3 trained vs. 9 projected	
Complete	B1b. Patient Privacy and Consent re: 42 CFR Part 2: 0 trained vs. 9 projected	
Complete	B2. CCSA and Universal Screening	
Complete	B2a. Dartmouth Hitchcock CCSA and SDOH Pathways Learning Session: 3 participated vs. 0 projected	
Complete	B2b. Engaging Community Partners in Addressing Social Determinants of Health Training provided by DHHS/Myers and Stauffer: 2 participated vs. 0 projected	
In progress	B2c. Use of CCSA process with overview of DN protocols/guidelines: 0 trained vs. 9 projected	expected to be conducted by December 31, 2018
In progress	B3. Use of HIT platforms (ENS, DSM, SCP) to support information sharing and communication workflows and protocols	
In progress	B3a. Use of [redacted] Data Portal and Patient Dashboard for IDN Data Reporting: 3 trained vs. 9 projected	
In progress	B3b. Use of [redacted] for Event Notification (ENS) and Shared Care Plan (SCP): 0 trained vs. 9 projected	expected to be conducted by December 31, 2018
In progress	B3c. Use of [redacted] for Direct Secure Messaging (DSM): 0 trained vs. 9 projected	expected to be conducted by December 31, 2018
Complete	B4. Understanding Addiction and Treating Patients with Co-Occurring Disorders:	
Complete	B4a. Initial Training on Addiction, provided by BDAS: 5 trained vs. 8 projected	
Complete	B4b. Co-Occurring Disorders (SUD and Mental Health): 3 trained vs. 9 projected	
Complete	B4c. Co-Occurring Disorders (Medical and Behavioral Health Disorders): 0 trained vs. 9 projected	expected to be conducted by December 31, 2018
Complete	B4d. Motivational Interviewing: 3 trained vs. 9 projected	
Complete	B5. Cultural Competency and Adaptation	
Complete	B5a. Unpacking Assumptions: 3 trained vs. 9 projected	
Complete	B5b. Stigma Across Cultures: 1 trained vs. 9 projected	
Complete	III. Staff vacancy and turnover rate for period and cumulative vs. projected	
Not started	A. 3 vacant positions (1.7 FTEs) vs. 0 projected	

Not started	A1. Detox and Non-Detox Nurses and Peer Support Specialist co-facilitator	
Complete	IV. Impact measures as defined in evaluation plan	
Complete	A. Up to 9 DN-funded positions in the D3 strategies participate in universal screening training by 12/31/18.	Progress met: 3 staff funded through D3 participated in educational opport/trainings.
Complete	B. Up to 9 DN-funded positions in the D3 strategies participate in universal screening training by 12/31/18.	Progress not met: while trainings were held during the reporting period, additional trainings are expected Fall 2018.
Complete	C. Up to 9 IDN-funded positions in the D3 strategies participate in training on communication protocols and workflows (through HIT vendor technologies) by 12/31/18.	In progress: training was provided by [redacted] in January 2018, with 3 of the 9 staff funded in D3 participating. Additional training from [redacted] is expected in the Fall 2018. Training provided by [redacted] on ENS and SCP, as well as [redacted] on DSM are expected in Fall 2018.
Complete	D. Up to 4 of the IDN-funded positions in the D3 strategies participate in the ASAM training by 12/31/18.	In progess: While ASAM training was not provided to members of the D3-funded strategies during this reporting period, 5 of the 9 staff participated in the Initial Training on Addiction in May 2018 as well as 3 of the 9 staff participating in the Co-Occurring Disorders (Mental Health and SUD) in June 2018. Additional training in this area is expected to be provided later in 2018 or in early 2019.
Complete	E. Up to 10 Primary Care Physicians (PCPs) across the IDN Member provider practices have met with the IDN funded Student Assistance Program Counselors to receive information about SB RT and referral resources by 12/31/18.	Progress not met: this is part of a larger education effort provided by the IDN as part of its A1 project strategy to engage providers in universal screening.
Complete	F. Brief intervention/education and assessment services provided by Project IMPACT counselor(s) for up to 60 Nashua Middle School students by the end of the first sub-contracting period (June 30, 2018)	Progress met: 58 middle school youth were referred to Project IMPACT counselors, with 13 of those screened with the SB RT tool, identifying only one of 13 had used substances. However eight of 13 (61 5%) screened positive for signs of depression, with seven of the eight youth were reportedly receiving services for those concerns. Additionally, the Project MPACT Questionnaire was administered to 17 youth on protective factors for at-risk youth. The post-test results will be shared with the IDN.
In progress	G. Referrals for well-child visits to PCPs for up to 10 students who had not previously completed a well-child (physical) visit in the last 12 months, using appropriate consent procedures by the end of the first sub-contracting period (June 30 2018).	In progress: protocols and tracking mechanisms are still being determined by the team, in collaboration with the DN Clinical Governance Committee, expected to be finalized by September 2018.
Complete	H. Referrals to higher levels of services or other supports for students not appropriate for brief intervention/education based upon completion of the S2BI tool.	20 Middle school youth were referred for more BH therapy sessions with Youth Council and their affiliate Providers; 7 were referred to PCP for well care visits; 39 were referred to after school programs but only 7 enrolled in the programs and are participating in after school activities.
Complete	I. New relationships with up to 5 primary care physician practices through up to 10 presentations to providers to educate them about the services available from Project IMPACT by December 31 2018.	Progress met: The Youth Council's Project MPACT engaged with Harbor Homes, Lamprey Health, and Main Street Pediatrics and Adolescent Medicine.
In progress	J. Treatment provided through medical detox/Medication Assisted Treatment (MAT) to up to 125 patients by the end of the end of the sub-contracting period (June 30, 2018)	Progress not met: The Partnership for Successful Living has had significant turnover in leadership and is evaluating timing and ability to implement strategies within the DN, with the expectation of making decisions in early 2018.
Complete	K. Up to 80 individuals will participate in the community-based pre-treatment groups and/or the spirituality non-treatment groups by the end of the first sub-contracting period (June 30 2018)	Progress not met: both the GNMHC and Emmaus Institute sub-contracts are in progress, with identification of outreach methods, locations, and tracking/referral protocols which are expected to be finalized in early 2018.
Complete	L. Up to 125 patients seen in the Emergency Departments at SNHMC and St. Joseph Hospital will participate in screening/assessment and discharge/referral to IDN Member Entity SUD treatment providers by the end of the sub-contracting period (June 30, 2018)	Progress not met: expectation to begin supporting patients by October 30, 2018 due to delays caused by health system's EHR migration and turnover in leadership. Dartmouth Hitchcock AmeriCorps VISTA has been engaging in support for this role in the interim with the SJH Emergency Department (Daniel R.) as of April 2018, through funding support from the IDN (A1 project funds)
In progress	Stage 2: Project Utilization Milestones (Ongoing Data Reporting) July to December 2018	
In progress	A. Number of individuals served (during reporting period and cumulative), vs. projected	
In progress	B. Number of staff recruited and trained (during reporting period and cumulative) vs. projected	
In progress	C. Staff vacancy and turnover rate for period and cumulative vs. projected	
	D. Impact measures as defined in evaluation plan	

Project Team Member	Training/Support Target Date	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress	6/30/19 Progress
Student Assistance Counselor (The Youth Council)					
Training					
HIPPA and Secure Data Storage	January - March 2018	In Progress This training wi l be provided by the IDN 2 separate days/times via webinar March 19 and 30, 2018	Progress not met this role did not participate in the trainings provided by the IDN (March 2018). More trainings on this topic will be provided later in 2018 or early 2019.		Progress not met this training was not provided during the reporting period
Universal Screening/Assessment Tools	January - July 2018	Progress Not Met These trainings will be provided by mid-2018 as part of the Multi-Disciplinary Core Team (MDCT) training to increase knowledge of providers and care coordinators/case managers of the IDN's use of a Comprehensive Core Standardized Assessment (CCSA), which will include use of universal screening tools PHQ-2/9 and SBIRT.	Progress not met this role did not participate in any of the trainings provided, but the IDN wi l be provided additional trainings specific to the CCSA and universal screening by December 31, 2018.		n/a as this role is not executing CCSAs
Patient Privacy and Consent related to 42 CFR Part 2	December 2017 - April 2018	Progress Met The Youth Council participated in the Patient Privacy Boot Camps held by the UNH Law School May - June 2017. Additional in-person trainings will be provided to IDN treatment providers in mid-2018.	Progress not met this training was not provided during the reporting period, but is expected to be provided by December 31, 2018.		Progress not met this training was not provided during the reporting period
Communication Protocols and Workflows (through HIT vendor technologies)	December 2017 - December 2018	Progress Met The Youth Council participated in the IT/Data and Clinical Governance Committee educational sessions provided by both [redacted] (September 2017) and [redacted] (October 2017).	Progress not met this role did not participate in the training provided by [redacted] (May 2018). Trainings for the use of [redacted] (event not fication and shared care plan) and [redacted] (direct secure messaging) will be held in late 2018.		n/a as this role w ll not interact w th HIT vendor technologies
American Society of Addiction Medicine (ASAM) Criteria guide ines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring cond tions	December 2017 - December 2018	Progress Not Met This training is being planned for mid-2018.	Progress not met this training was not provided during the reporting period, but is expected to be provided by December 31, 2018.		Progress not met this training was not provided during the reporting period
Recovery/Transitional Care Coordinator (St. Joseph Hosp ta)					ROLE NOT IN PLACE
Recovery/Transitional Care Coordinator (Southern NH Medical Center)					
Training					
HIPPA and Secure Data Storage	January - March 2018	N/A This position not yet been on-boarded as an IDN-funded pos tion (it is currently being piloted under an outside grant). It is expected a sub-contract w th the IDN to fund this pos tion/strategy will be executed by early-mid 2018. These trainings will be provided by mid-2018 as part of the Multi-Disciplinary Core Team (MDCT) training to increase knowledge of providers and care coordinators/case managers of the IDN's use of a Comprehensive Core Standardized Assessment (CCSA), which wi l include use of universal screening tools PHQ-2/9 and SBIRT.	Progress not met this role did not participate in the trainings provided by the IDN (March 2018). More trainings on this topic will be provided later in 2018 or early 2019.		Progress not met this training was not provided during the reporting period
Universal Screening/Assessment Tools	January - July 2018	N/A This position not yet been on-boarded as an IDN-funded pos tion (it is currently being piloted under an outside grant). It is expected a sub-contract w th the IDN to fund this pos tion/strategy will be executed by early-mid 2018. This training w ll be provided to IDN treatment providers in mid-2018.	Progress not met this role did not participate in any of the trainings provided, but the IDN wi l be provided additional trainings specific to the CCSA and universal screening by December 31, 2018.		n/a as this role is not executing CCSAs
Patient Privacy and Consent related to 42 CFR Part 2	December 2017 - April 2018	N/A This position not yet been on-boarded as an IDN-funded pos tion (it is currently being piloted under an outside grant). It is expected a sub-contract w th the IDN to fund this pos tion/strategy will be executed by early-mid 2018. Training/educational opportunities wi l be provided for use of [redacted] and [redacted] as well as other HIT platforms by mid-2018.	Progress not met this training was not provided during the reporting period, but is expected to be provided by December 31, 2018.		Progress not met this training was not provided during the reporting period
Communication Protocols and Workflows (through HIT vendor technologies)	December 2017 - December 2018	N/A This position not yet been on-boarded as an IDN-funded pos tion (it is currently being piloted under an outside grant). It is expected a sub-contract w th the IDN to fund this pos tion/strategy will be executed by early-mid 2018.Training/educational opportunities will be provided for use of [redacted] and [redacted] as well as other HIT platforms by mid-2018.	Progress not met this role did not participate in the training provided by [redacted] (May 2018). Trainings for the use of [redacted] (event not fication and shared care plan) and [redacted] (direct secure messaging) will be held in late 2018.		n/a as this role w ll not interact w th HIT vendor technologies
American Society of Addiction Medicine (ASAM) Criteria guide ines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring cond tions	December 2017 - December 2018	N/A This position not yet been on-boarded as an IDN-funded pos tion (it is currently being piloted under an outside grant). It is expected a sub-contract w th the IDN to fund this pos tion/strategy will be executed by early-mid 2018.Additional training will be offered as part of the annual IDN compliance, as well as part of the Patient Privacy and Consent trainings. The March 2018 trainings will also be recorded, with slides available to IDN members.	Progress not met this training was not provided during the reporting period, but is expected to be provided by December 31, 2018.		Progress not met this training was not provided during the reporting period
Detox Nurse (Keystone Hall/Harbor Homes)					ROLE NOT IN PLACE
Non-Detox Nurse (Harbor Homes/Keystone Hall)					ROLE NOT IN PLACE
Community-Based Spirituality Group Facil tator					
Training					
HIPPA and Secure Data Storage	January - March 2018	In Progress This training wi l be provided by the IDN 2 separate days/times via webinar March 19 and 30, 2018	Progress met this role participated in the training provided by the IDN in March 2018.		Achieved in prior reporting period
Universal Screening/Assessment Tools	January - July 2018	Progress Not Met These trainings will be provided by mid-2018 as part of the Multi-Disciplinary Core Team (MDCT) training to increase knowledge of providers and care coordinators/case managers of the IDN's use of a Comprehensive Core Standardized Assessment (CCSA), which will include use of universal screening tools PHQ-2/9 and SBIRT. However, the Licensed Pastoral Psychotherapists have been active participants in the CCSA Work Teams throughout 2017.	Progress met this participated in both the DH CCSA/Social Determinants of Health learning session (March 2018) and the Engaging Partners in Addressing Social Determinants of Hea th Training provided by DHHS/Myers and Stauffer (May 2018).		Achieved in prior reporting period
Patient Privacy and Consent related to 42 CFR Part 2	December 2017 - April 2018	Progress Not Met This training will be provided to IDN treatment providers in mid-2018.	Progress not met this training was not provided during the reporting period, but is expected to be provided by December 31, 2018.		Progress not met this training was not provided during the reporting period
Communication Protocols and Workflows (through HIT vendor technologies)	December 2017 - December 2018	Progress Met The Licensed Pastoral Psychotherapists participated in the IT/Data and C inical Governance Committee educational sessions provided by both [redacted] (September 2017) and [redacted] (October 2017).	Progress met this role participated in the [redacted] Data Portal training in January 2018. Trainings for the use of [redacted] (event not fication and shared care plan) and [redacted] (direct secure messaging) will be held in late 2018.		Achieved in prior reporting period

American Society of Addiction Medicine (ASAM) Criteria guide ines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring cond tions	December 2017 - December 2018	Progress Not Met This training is being planned for mid-2018.	In progress While the ASAM training was not provided, this role participated in the Initial Training on Addiction and Recovery training provided by BDAS (May 2018).		Progress not met this training was not provided during the reporting period
Community-Based Pre-Treatment Group Facilitator					ROLE NOT IN PLACE
Community-Based Pre-Treatment Group Co-Faci itator					ROLE NOT IN PLACE

Projects E: Capacity-Focused

attachment_E.1a IDN Community Project Implementation Plan
attachment_E.9: Community Project Training Plan

attachment_E.1a:
IDN Community Project Implementation Plan

Status	Task Name	Comments
Complete	Stage 1 Develop Implementation Plan (January - June 2017)	
Complete	I. Develop implementation timeline	
Complete	II. Develop Project Budget	
Complete	A. Review with Clinical Committee	
Complete	B. Present to Finance Comm tee for approval	
Complete	C. Present to Executive Committee for approval	
Complete	D. Budget approved	
Complete	III. Develop Workforce Plan	
Complete	A. Develop Staffing Plan	
Complete	B. Develop recruitment/retention strategies	
Complete	IV. Identify projected annual client engagement volumes	
Complete	A. Solicit input from IDN project partners	
Complete	B. Develop projections	
Complete	V. Ident fy key organizational/provider participants	
Complete	Stage 1 Design/Develop Clinical Services Infrastructure (January - June 2017)	
Complete	I. Complete consulting and training agreement with Case Western Reserve University to be funded under A1 BH Workforce Capacity Project	
Complete	A. IDN signs Scope of Work and Contract with Case Western Reserve University	
Complete	II. Identify/Develop Standardized Assessment Tools	
Complete	A. Consult with Case Western Reserve University to determine appropriate assessment tools to meet program fidelity	
Complete	III. Identify/Develop Patient Assessment, Treatment, Management and Referral protocols	
Complete	A. Consult with Case Western Reserve University to identify protocols	
Complete	IV. Identify/Develop Roles and Responsibilities for Multi-Disciplinary Core Team Members	
Complete	A. Consult with Case Western Reserve University to outline team member roles conforming to IDDT fidelity model	
Complete	V. Ident fy/Develop Training and Supervision Plan, Conforming to SAMSA "Training Front ine Staff" in Integrated Treatment for Co-Occurring Disorders	
Complete	A. Consult with Case Western Reserve University to write plan as part of fidelity action plan to include key deliverables	
Complete	VI. Identify/Develop Agreements w th Collaborating Organizations, Including Social Service Support Providers	
Complete	A. Identify co laborating organizations	
Complete	B. Obtain signed agreements with applicable co laborating organizations	
Complete	VII. Identify/Develop Evaluation Plan	
Complete	A. Identify target process and outcome goals in IDN sub-contract Scope of Work (SOW)	
Complete	A2. Consult with Case Western Reserve University to ident fy and target outcomes to meet fidelity	
Complete	VIII. Identify/Develop mechanisms (registries) to track and monitor patients served by program	
Complete	A. Utilize HIT platforms to track and mon tor (including [redacted] for Event Not fication Service and Shared Care Plan and [redacted] for Direct Secure Messaging)	
Complete	B. Utilize spreadsheets and electronic health record (EHR) within GNMHC to track and monitor progress and movement between stages of change and treatment	IDDT team supervisor is utilizing this method as of 5.10.18
Complete	Stage 1 Project Planning and Process Milestones (Operationalization of Program) July to December 2017	
Complete	I. Implementation of workforce plan	
Complete	A. Job descriptions created	
Complete	B. Jobs posted on IDN Career Board in advance of IDN Career Fair (September 2017)	As positions open up again, they are re-posted on IDN website, as we l as other social media outlets
Complete	C. Key core team staff on-boarded for initial pilot	Initial team members, including Team Lead, two Therapists (both Co-Occurring Disorder Therapists), and two Case Managers were on-boarded for December 2017 training
Complete	II. Deployment of training plan	
	A. IDDT Fidel ty and Staffing Core Competencies	
Complete	A1. IDDT Stages of Treatment Staff trained in first two stages (Engagement and Persuasion) provided by Case Western Reserve University	two sessions of Stages 1 and 2 completed (one in December 2017 and one in September 2018)
Complete	A2. IDDT Stages of Treatment (Action and Relapse Prevention) Staff trained by Case Western Reserve University	Being planned for early 2019
Complete	A3. Motivational Interviewing Staff trained in motivational interviewing provided by Peter F field	Completed in April 2018
Complete	A4. Motivational Interviewing Staff trained in motivational interviewing provided by David Lynde and Christine Powers	Completed in May 2018
Complete	A4a. Advanced Motivational Interviewing Staff trained in one-day advanced motivational interviewing provided by Peter Fifield	6 IDDT team members participated in this 2-day training in July 2018
Complete	B. Staff trained Patient Privacy and Consent 42 CFR Part 2	
Complete	B1. HIPAA and Secure Data Storage Staff trained in overview of HIPAA and how to securely store PHI data provided by the IDN	
Complete	B2. 42 CFR Part 2 and protection of sensitive information	Expected to be completed in early 2019
Complete	C. Staff trained in Universal Screening	
Complete	C1. CCSA/SDOH and pathways Staff participated in learning session hosted by Dartmouth Hitchcock on their pilot of the social determinants of health screening domains and their use of pathways	
Complete	C2. Use of CCSA process w th overview of IDN protocols/guide lines	
Complete	D. Staff trained in Cultural Competence and Adaptation	
Complete	D1. Unpacking Assumptions Staff engaged in learning about how assumptions impact providing hea th care and social services support to those in our region who may come from different cultures provided by Ascentria Care Alliance	
Complete	D2. Stigma Across Cu tures Staff engaged in learning about various cultures who live in the greater Nashua area and how stigma affects their health care and daily living provided by Ascentria Care Alliance	
Complete	E. Staff trained in Care Planning and Care Coordination	
Complete	E1. Change Management Staff were provided with an overview of the stages of change management and engaged with others around the state to work through a scenario to support this work within their own IDNs provided by DHHS and Myers and Stauffer	2 IDDT team members participated in this training in February 2018
Complete	E2. WRAP/Case Management Staff were provided with an overview of the NH WRAP program and learned more about case management and care coordination strategies being implemented in the greater Nashua region provided by DHHS, the NH Children's Behavioral Co laborative, NAMI, and Nashua Wrap-Around team	4 IDDT team members participated in this workshop as part of the IDN Shared Care Plan and Case Management Work Team April 2018 meeting
Complete	F. Staff trained in Co-Occurring Disorders	
Complete	F1. Dual Diagnosis Capab lity Program Leader Training Staff trained in the DDAC model in this statewide training provided by Case Western Reserve University and sponsored by IDN 4	
Complete	F2 Co-Occurring Disorders (SUD and Mental Health) Staff trained in an overview of co-occurring disorders including prevalence and screening provided by NH Healthy Fam lies	
Complete	F3. Co-Occurring Disorders medical conditions and BH conditions	
Complete	G. Staff trained in Understanding Addiction	
Complete	G1. American Society of Addiction Medicine (ASAM) Staff trained on ASAM criteria provided by Trish Ledbetter	7 IDDT team members participated in this training in January 2018
Complete	G2. Initial Training on Addiction Staff trained in understanding the basics of addiction, provided by BDAS, in collaboration with IDN 4	3 IDDT team members participated in this training in January 2018
Complete	H. Team engages in programmatic and clinical consu tation with Case Western Reserve University	
Complete	III. Implementation of any required updates to clinical protocols, or other operating policies and procedures	
Complete	A. Addition of staging of treatment incorporated into case review workflow and documentation	
Complete	B. Weekly supervision technical assistance w th Case Western with team changes	
Complete	IV. Use of assessment, treatment, management and referral protocols	
Complete	A. Use of patient assessment protocols	
Complete	B. Use of patient treatment and management protocols	During the initial phase of treatment clients will be admitted to 1 1 therapy once a week, group therapy twice a week, community based services once a week, and receive case management and medication services on an on-going basis. Treatment is non-linear and follows patient's needs, which are reviewed at least every 3 months.
Complete	C. Use of patient referral protocols	
Complete	Stage 2 Project Uti lization Milestones (In tiation of Data Reporting) July to December 2017	
Complete	I. Report on number of individuals enrolled (during repoting period and cumulative), vs. projected	
Complete	A. 6 enrolled since July 2017 vs. 0 projected	0 were projected due to on-boarding and training of staff expected during this reporting period
Complete	II. Report on number of staff recru ted and trained (during reporting period and cumulative) vs. projected	
Complete	A. Number of staff recruited/on-boarded vs. projected 4 FTEs recruited/retained vs. 7.3 FTEs projected	4.8 FTEs recru ted/retained vs. 7.3 FTEs projected
In progress	III. Report on impact measures as defined in evaluation plan, including annual evaluation of fidel ty to evidence-supported program elements	Team is still working through indicators and tracking mechanisms
Complete	A. IDDT Fidel ty Baseline Assessment completed by Case Western Reserve University	Completed
Complete	Stage 2 Project Uti lization Milestones (Ongoing Data Reporting) January to June 2018	
Complete	I. Data reporting on number of individuals served (during reporting period and cumulative), vs. projected	
Complete	A. 44 enrolled since December 2017 vs. 30 projected	
Complete	II. Report on number of staff recru ted and trained (during reporting period and cumulative) vs. projected	
Complete	A. Number of staff recruited/on-boarded vs. projected 4.8 FTEs recru ted/retained vs. 7.3 FTEs projected	
Complete	B. Number of staff trained vs. projected	
In progress	B1. IDDT Fide ity and Staffing Core Competencies	Stages 1 and 2 training completed (Dec 2017 and Sept 2018) with Stages 3 and 4 to be conducted in early 2019
In progress	B2. Staff trained Patient Privacy and Consent 42 CFR Part 2 vs. Projected	
In progress	B3. Staff trained in Universal Screening vs. Projected	

Complete	B4. Staff trained in Cultural Competence and Adaptation vs. Projected	
In progress	B5. Staff trained in Care Planning and Care Coordination vs. Projected	
In progress	B6. Staff trained in Co-Occurring Disorders vs. Projected	
Complete	B7. Staff trained in Understanding Addiction vs. Projected	
Complete	III. Reporting on staff vacancy and turnover rate for period and cumulative vs. projected	
Complete	IV. Reporting on impact measures as defined in evaluation plan	
Complete	Stage 2 Project Utilization Milestones (Ongoing Data Reporting) July to December 2018	
Complete	I. Number of individuals served (during reporting period and cumulative), vs. projected	
Complete	A. 75 enrolled since December 2017 vs. 60 projected	
Complete	II. Number of staff recruited and trained (during reporting period and cumulative) vs. projected	
Complete	A. Number of staff recruited/on-boarded vs. projected 8 vs. 10	
Complete	B. Number of staff trained vs. projected see below	
Complete	B1. IDDT Fidelity and Staffing Core Competencies	
Complete	B1a. IDDT Stages of Treatment (Stages 1 and 2) 10 staff trained vs. 10 projected	
In progress	B1b. IDDT Stages of Treatment (Stages 3 and 4) 10 staff trained vs. 10 projected	
Complete	B1c. Advanced Motivational Interviewing 4 trained	
Complete	B2. Staff trained Patient Privacy and Consent 42 CFR Part 2 vs. Projected	
Complete	B2a. HIPAA and Secure Data Storage 3 staff trained vs. 10 projected	
Complete	B3. Staff trained in Universal Screening vs. Projected	
Complete	B3a. Use of CCSA process with overview of IDN protocols/guidelines 1 staff trained vs. 10 projected	
Complete	B4. Staff trained in Cultural Competence and Adaptation vs. Projected	
Complete	B4a. Unpacking Assumptions and Stigma Across Cultures 7 staff trained across two trainings vs. 10 projected	
Complete	B5. Staff trained in Care Planning and Care Coordination vs. Projected	
Complete	B5a. Change Management and WRAP/Case Management 5 staff trained vs. 10 projected	
Complete	B6. Staff trained in Co-Occurring Disorders vs. Projected	
Complete	B6a. Chronic Disease and Behavioral Health 6 staff trained vs. 10 projected	
Complete	B7. Staff trained in Understanding Addiction vs. Projected	
Complete	B7a. American Society of Addiction Medicine (ASAM) and Initial Training on Addiction and Understanding Addiction 9 staff trained vs. 10 projected	
Complete	III. Staff vacancy and turnover rate for period and cumulative vs. projected	
Complete	A. 2.5 positions vacant/turned over for period vs. projected	
Complete	IV. Reporting on impact measures as defined in evaluation plan	
Complete	A. A minimum of 60 individuals from the target sub-population are served by the IDDT program by December 31 2018.	Achieved The maximum caseload per program fidelity has been reached at 75
Complete	B. A minimum of 30 individuals from the target sub-population are served by the IDDT program by June 30, 2018.	Achieved The maximum caseload per program fidelity has been reached at 75
Complete	C. Up to 8 members of the IDDT team report increased knowledge of the IDDT evidence-based fidelity model of treatment for co-occurring disorders through training provided by Case Western Reserve University by June 30 2018.	Achieved Team participated in Case Western training in September 2018 and have participated in bi-weekly (minimum) technical assistance.
Complete	D. Up to 8 members of the IDDT team report increased skills in implementing the IDDT evidence-based fidelity model of treatment for co-occurring disorders, ensuring compliance with the fidelity of the program through training provided by Case Western Reserve University by June 30 2018.	Achieved Team participated in Case Western training in September 2018 and have participated in bi-weekly (minimum) technical assistance.
Complete	E. Up to 8 members of the IDDT team report increased knowledge of patient consent requirements related to HIPAA and 42 CFR Part 2 to guide the treatment and management of the target sub-population through engaging in training by June 30, 2018.	Not achieved
Complete	F. Up to 8 members of the IDDT team report increased knowledge of the standardized processes and tools to meet program fidelity by June 30, 2018.	Achieved Team participated in Case Western training in September 2018 and have participated in bi-weekly (minimum) technical assistance.
Complete	G. The written patient referral process is developed with support from the IDN Clinical Governance Committee and Administrative Lead, with consultation from Case Western Reserve University by February 28, 2018.	Achieved The referral form has been further refined/improved in the EMR with community partners being education on the inclusion/exclusion criteria for IDDT in conjunction with the SUD and ACT teams, so GNMHC's array of services are being shared with partners.
Complete	H. Up to 8 members of the IDDT team report increased knowledge of care planning and care coordination models to guide the treatment and management of the target sub-population through education and training opportunities provided by the IDN by June 30 2018.	Achieved Team participated in Case Western training in September 2018 and have participated in bi-weekly (minimum) technical assistance.
Complete	I. Up to 3 case management meetings are held within the IDN region to support increased knowledge for the IDDT team members' treatment and support services for the target sub-population by June 30 2018.	Achieved The IDDT team has met with staff from InteGreat Health to conduct case management and has received training in assessing daily functioning including the social determinants of health.
Complete	J. Written protocols for patient screening and assessment are finalized with support from the IDN Clinical Governance Committee and Administrative Lead, with consultation from Case Western Reserve University by June 30 2018.	Achieved Completed as part of Fidelity Action Plan.
Complete	K. Up to 30% of clients engaged in IDDT demonstrate independent living skills by December 31, 2018.	Achieved IDDT referral form added into our EMR used internally and form Open Access at GNMH. All clients screened with ANSA and for Case Management needs.
Complete	L. Up to 30% of clients engaged in IDDT maintain employment by December 31, 2018.	Not Achieved GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.
Complete	M. New information sharing and communication platforms are incorporated into existing protocols and workflows with care team members treating clients in the IDDT program by December 31, 2018.	Achieved Contracting and operationalization steps have been completed with [redacted] to enable the ability to receive emergency department, urgent care, and inpatient admissions, discharges and transfers (ADTs). Contracting and operationalization steps also completed with [redacted] to enable direct secure messaging (DSM).
Complete	N. Up to 30% of clients engaged in IDDT will report improvement in functioning by December 31, 2018.	Not Achieved GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.
Complete	O. Up to 30% more clients maintain regular contacts with non-substance misusers by December 31, 2019.	Not Achieved GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.
Complete	P. Up to 50% of clients engaged in IDDT maintain their supportive housing contracts as of December 31, 2019.	Not Achieved GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report.
Complete	Q. Up to 50% of clients engaged in IDDT stay out of incarceration by December 31, 2019.	Not Achieved GNMHC has baseline data, but was unable to provide it by the deadline of publication of this report. However, GNMHC is working with the mental health court liaison to assist clients in remaining in the community.
Complete	R. Up to 50% of clients report improved experience with treatment by December 31, 2019.	Not achieved DSRIP Experience of Care survey has not yet been implemented by the University of Southern Maine as part of the DSRIP Evaluation plan.
Complete	S. Up to 50% of clients in IDDT will not revisit hospital emergency departments or be placed in NH Hospital while engaged with IDDT integrated services by December 31, 2019.	Not Achieved No data available at the time of publication of this report.
Complete	T. Up to 30% of clients engaged in IDDT will report positively controlling symptoms of psychosis and schizophrenia by December 31 2019.	Not Achieved This will be monitored, as repeat assessments of the ANSA are not sensitive enough to distinguish. It is expected that use of the DLA 20 will provide more sensitive data to show change.
Complete	U. Up to 50% of clients in IDDT are actively attaining remission from substance use by December 31, 2020.	Not Achieved Stages of change are being tracked and clients are making changes, but GNMH is still working on quantifying this data.
Complete	V. Treatment providers supporting IDDT clients will report up to 75% less duplication of services compared to the baseline (January 2018).	Not Achieved Awaiting implementation of DSRIP Patient Satisfaction Survey through University of Southern Maine.
Complete	W. The IDDT program will achieve up to 75% of the fidelity model characteristics (organizational and treatment) targets by December 31 2020.	In progress This work continues with Case Western Reserve University, with a one-year fidelity review being completed in early 2019.

Training/Education Topic	Training/Support Target Timeframe	Entity/Individual Responsible	Role	Credentials	06/30/18 Progress	12/31/18 Progress	6/30/19 Progress
I. Programmatic Consultation and Readiness Assessment	October - December 2017	Case Western Reserve University (CWRU) and GNMHC				Achieved	
A. Complete IDDT Readiness Assessment						Achieved	
II. IDDT Program Fidelity: Assessment, Implementation Action Plan Development and Monitoring	December 2017 - December 2020					In Progress	
A. Complete Baseline Fidel ty Assessment and Share Recommendations for Action Plan	December 2017 - February 2018					Achieved	
B. Develop Fidelity Action Plan	March 2018					Achieved	
C. Conduct Formal Action Plan Reviews with Full IDDT Team	every 6 months					In progress	
C1. Complete Review #1	September 2018	Full IDDT Team and CWRU			N/A	In progress delayed due to contracting w th Case Western Reserve University; expected to be completed in early 2019	
C2. Complete Review #2	March 2019	Full IDDT Team and CWRU			N/A	N/A	Pending response from Case Western
C3. Complete Review #4	March 2020	Full IDDT Team and CWRU			N/A	N/A	
D. Conduct Follow-up Fidelity Assessment	September 2019					In progress	In progress. Was scheduled for July 2019; rescheduled due to contracting; will be rescheduled in e ther September or October 2019
D1. Follow-up assessment conducted to measure progress toward program fidel ty		CWRU			N/A	N/A	
E. Conduct Final Fidelity Assessment	September/October 2020					N/A	To be scheduled after 2019 assessment; may be early 2021
E1. Follow-up assessment conducted to measure where program fide ity is near end of DSRIP demonstration		CWRU			N/A	N/A	
III. IDDT Team Builds Core Competencies to Ensure Program Fidelity	December 2017 - December 2019					In progress	
A. IDDT team participates in training to build core competencies	December 2017 - June 2019					In progress	
A1. Stages of Change Training						In progress Stages of Change 1 and 2 have been conducted; Stages of Change 3 and 4 are expected in early 2019	
A1a. Team participates in Stage-wise Treatment Training Stages 1 (Engagement) and 2 (Persuasion)	December 5-6, 2017	CWRU			N/A	Achieved	
A1b. Team participates in "reboot" of Stages 1 (Engagement) and 2 (Persuasion) Stage-wise Treatment Training (due to team turnover and new	September 25-26, 2018	CWRU			N/A	Achieved 10 individuals trained	
A1c. Team participates in Stage-wise Treatment Training Stages 3 (Action) and 4 (Relapse Prevention)	December 2018	CWRU			N/A	Not Achieved planned for early 2019	
A2. Motivational Interviewing Training						Achieved	
A2a. Motivational Interviewing (2-day)	March 26, 2018 and April 2, 2018	Peter F field			Progress met 7 IDDT team members participated in training	Achieved	
A2b. Motivational Interviewing (2-day training)	June 21 and 28, 2018	David Lynde and Christine Powers			Progress met 7 IDDT team members participated in training	Achieved	
A2c. Advanced Motivational Interviewing	July 30, 2018	Peter F field			N/A	Achieved	
A3. Team participates in trainings on patient privacy and consent, including HIPAA and 42 CFR Part 2	By June 30, 2018					Achieved	
A3a. HIPAA and Secure Data Storage Training	March 30, 2018	Valerie Fryatt and Donna Stone, SNHHS			Progress met 3 IDDT team members participated in training	Achieved 3 members of IDDT team engaged in training; additional training is expected by June 30, 2019	Achieved for all current staff if GNMH training on the topic is considered complete
A4. Team participates in Multi-Disciplinary Core Team (MDCT) training on universal screening	By June 30, 2018					Achieved	
A4a. CCSA/universal screening conducted	March 19, 2018	Dartmouth Hitchcock			Progress met 4 IDDT team members participated in training	Achieved 4 members of IDDT team engaged in training; additional training expected to be provided by June 30 2019	Achieved for all current staff if GNMH training on the topic is considered complete
Jenna M. (1 FTE)			Therapist	LCMFT	Y		
Jennifer B. (1 FTE)			Therapist	LCMHC	Y		
Camila F. (1 FTE)			January 2017 - Apr l 2018 IDDT Coordinator	MSW	Y		
Jenna M. (1 FTE)			Therapist	LCMFT	Y		
Marie M. (1 FTE)			Team Lead	Psy.D.	Y		
A5. Team participates in Multi-Disciplinary Core Team (MDCT) training on cultural competence and adaptation	By June 30, 2018					Achieved	
A5a. Unpacking Assumptions/Stigma Across Cultures	March 23, May 3 and October 2018	Ascentria Care Alliance			Progress met 4 IDDT team members participated in training	Achieved 10 IDDT team members participated in training	
A6. Team participates in Multi-Disciplinary Core Team (MDCT) training on understanding addiction	By December 31, 2018					Achieved	
A6a. American Society of Addiction Medicine (ASAM)	January 29, 2018	Trish Ledbetter, GNMHC			Progress met 7 IDDT team members participated in training	Achieved	
A6b. Initial Training on Addiction in partnership w th IDN 4	May 10, 2018	BDAS			Progress met 3 IDDT team members participated in training	Achieved	
A7. Team participates in Multi-Disciplinary Core Team (MDCT) training on care planning and care coordination	By December 31, 2018					Achieved	
A7a. Statewide Quarterly Learning Collaborative on Change Management	February 23, 2018	Myers and Stauffer			Progress met 2 IDDT team members participated in training	Achieved	
A7b. IDN Case Management Work Team meeting featuring DHHS Bureau for Children's Behavioral Health Wrap-around Program overview, as we l as Nashua Children's WRAP program	April 19, 2018	DHHS Bureau for Ch ldren's Behavioral Health and Nashua Children's WRAP			Progress met 4 IDDT team members participated in training	Achieved	
A7c. NH Behavioral Health Summit	December 10-11, 2018						
A8. Team participates in Multi-Disciplinary Core Team (MDCT) training on co-occurring disorders	By December 31, 2018					Achieved	
A8a. Dual Diagnosis Capability Program Leader training hosted by IDN 4	January 30 - 31, 2018	CWRU			Progress met 3 IDDT team members participatedin training	Achieved	
A8b. Co-Occurring Disorders (SUD and Mental Health)	June 22, 2018	NH Healthy Fami ies			Progress met 1 IDDT team member participated in training	Achieved	
Marilou P.			Psychiatrist	MD	Y		
A8c. Chronic Disease and Behavioral Health	October 2018	Tracy Tinker				Achieved	
Marie M.			IDDT Team Coordinator	Psy.D.	Y		
A8d. NH Behavioral Health Summit	December 10-11, 2018					Achieved	
Marie M.			IDDT Team Coordinator	Psy.D.	Y		
B. Team participates in both team-based and individual technical assistance with CWRU	December 2017 - December 2020					Achieved calls occur minima ly monthly, w th team lead and implementation team meeting more often	Ca ls with team and with coordinator were ongoing through May; were suspended in June due to contracting, will resume in July
B1. Team engages in technical assistance calls with Case Western Reserve University	January 2018 - September 2019						see above
2018						Achieved	
2019							
January					N/A	N/A	Y
February					N/A	N/A	Y
March					N/A	N/A	Y
April					N/A	N/A	Y
May					N/A	N/A	Y
June					N/A	N/A	
July					N/A	N/A	
August					N/A	N/A	
September					N/A	N/A	
October					N/A	N/A	
November					N/A	N/A	
December					N/A	N/A	
B2. IDDT Coordinator engages in supervision technical assistance calls with Case Western Reserve University	January 2018 - September 2019						Achieved during all months except June when calls were suspended due to contracting
2018						Achieved	
2019							
January					N/A	N/A	Y
February					N/A	N/A	Y
March					N/A	N/A	Y
April					N/A	N/A	Y
May					N/A	N/A	Y
June					N/A	N/A	
July					N/A	N/A	
August					N/A	N/A	

September					N/A	N/A	
October					N/A	N/A	
November					N/A	N/A	
December					N/A	N/A	