



**New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver  
Greater Nashua Integrated Delivery Network (IDN 3)  
Semi-Annual Report  
Year 3 (CY2018) July – December 2018**

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## ***DSRIP IDN Project Plan Implementation (PPI)***

### **Progress on Required Activities, Key Milestones and Progress Assessment Checkpoints**

For detailed information related to the IDN Project Plan Implementation, please see attachment PPI.a.

#### **IDN Team Infrastructure**

In support of executing to the DSRIP implementation plans, IDN3 has implemented a number of foundational changes to their approach in working with both the governance teams as well as the partner membership during this reporting period. These additional supporting infrastructure components have begun to make a difference but have not yet had an opportunity to demonstrate full impact. It is anticipated that over the course of this current reporting period there will be marked improvement towards making significant progress in achievement of the demonstration's goals. These additional supports include:

- Work Plans:
  - o A work plan has been developed for every IDN partner member regardless of the level of engagement in the demonstration. These work plans include milestones, deliverables, expected outcomes and required reporting due from the partner. The work plan provides visibility to expectations throughout the course of the demonstration, provides a common repository to store successes, challenges, barriers and mitigations and supports the IDN Admin team in having real-time access to the status of partner progress to goals in order to use for reporting purposes.
  
- Partner liaison model:
  - o With the intent of providing appropriate levels of support to IDN partner members, the IDN Admin team has developed a partner liaison model where 3 IDN Admin Team project staff have been assigned community partners to be responsible for working with. The partner liaison leverages the work plan noted above to reference during partnership meetings and captures notes related to progress, barriers and mitigations. Expectations have been set that meetings will be held with key partners at least monthly, in order to track to the expected milestones and deliverables noted in the work plan.
  
- Project dashboards:
  - o Beginning in September 2018, monthly dashboards for the A1, A2 and B1 projects have been developed, maintained and shared across all stakeholders in the demonstration including governance committees and the Full IDN membership. These dashboards provide visibility to, and transparency of, the successes, challenges and mitigation plans within each project. The content of the dashboards continues to evolve as feedback is received as to content and the relevancy of the information shared.



## IDN 3 DSRIP Demonstration Waiver Executive Summary

Overall Status: Week Ending: 1/11/19 Y

Admin Team: L. Madden, M. Craig, K. Kayira, 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:** County funding continues to be unknown with uncertainty in timing for resolution

**Result:** Difficult decisions may need to be made as to impact to partner funding

**Issue:** No partner achieved "SAMHSA Plus" Coordinated Care Practice designation by the 12/31/18 target date

**Result:** Anticipated financial implications to performance based funding will impact funding to allocate to IDN partner organizations

### Mitigations to Project Risks

- Implications to program outcomes highlighted and shared with the commissioner of DHHS in support of escalation of concern if county funding is not provided
- Partner liaisons leveraging individualized partner work plans to track progress to coordinated care, prioritize most relative milestones, escalate associated concerns, and support partners towards achievement of deliverables.

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

### Project Work Streams

Work Stream	Status
A1 – Building Workforce Capacity	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
A2 – Health Information Technology	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Health Information Technology Implementation Status by Partner	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
B1 – Integrated Health	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Integrated Health Implementation by Partner	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>



## IDN 3 DSRIP Demonstration Waiver A1: Behavioral Health Capacity Building

Overall Status: Week Ending: 1/11/19 Y

### Recent Accomplishments

1. Strong partner turnout at the December Behavioral Health Conference maximizing IDN3 scholarships offered

### Project Issues/Risks

1. Training by members of partner multi-disciplinary core teams is minimal resulting in potential negative impact to funding
2. Delays in receipt/processing of partner invoices delaying opportunity to expend funds allocated to the demonstration

### Mitigation to Risks

1. Training opportunities for multi-disciplinary core team members will be targeted in order to enhance participation
2. Partner liaisons will work closely and support IDN partners through the invoicing process

### Project Deliverables

Deliverable	Key Driver to Status	Status
Participation in Statewide Behavioral Health Workforce Capacity Taskforce	Recruitment/Hiring subcommittee, chaired by IDN3, active in executing statewide project plan	<span style="background-color: green; border: 1px solid black; padding: 2px;">G</span>
Development/implementation of Workforce Capacity Development Implementation Plan	IDN Admin Team focus on other key priorities	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Workforce Recruitment & Hiring	Minimal partner usage of sign-on bonus, referral bonus, relocation expenses	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Workforce Retention & Sustainability	Minimal partner usage of student loan payment, tuition/license fee reimbursement monies	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Workforce Training & Education	Partner participation in training is low forcing continued cancellation of trainings & potential funding impact	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Spending to Budget	Delays in receipt of partner invoices minimizing usage of workforce monies	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>

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 A2: Health Information Technology to Build Infrastructure

Status: Week Ending: 1/11/19 Y

### Recent Accomplishments

- DH & GNMHC continue to deliver monthly production files to MAeHC for 12/18 reporting period; The Emmaus Institute and Youth Council provided data for July – Dec. 2018 reporting period via the Manual Entry Portal; STJ and Lamprey have completed its reporting writing and in the process of providing production data;
- 1-1 partner liaison meetings for HIT introduction with Ascentria, Lamprey occurred throughout the month
- Life Coping, NAMI, Ascentria, The Youth Council engaged with Sage for late Feb. 2019 NIST assessment
- GNMHC, The Youth Council, Ascentria, Life Coping, Lamprey, The Emmaus Institute and Crochet Mountain are in progress of acquiring or completing their installation process with CMT
- No December Data/IT Gov. Comm. Meeting held however, Patrick U. has been engaged with Kno2 regarding new contract pricing;

### Project Issues/Risks

**Issue:** IDN sub-contracting, including BAA/QSOA and DUA still in progress for some treatment providers.

**Result:** Performance outcome measure reporting delayed with several partners and moving forward with NIST, CMT and Kno2 contracting subsequently delayed

### Mitigation to Risks

- Simplified IDN sub-contracting process to address partner concerns
- Liaisons working with partners with their Work Plans, sub-contracting execution & holding 1-1 HIT introduction/overview meetings

### Project Deliverables

Deliverable	Key Driver to Status	Status
Data Extraction/Validation for DHHS Reporting & IDN 3 Performance Measure Reporting	Data aggregation reporting to MAeHC & IDN Admin Lead Portal Access	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Event Notification (ENS) Generation, Transmission and Reception	CMT Pre-Manage ED & Pre-Manage ENS implementation - need DUA*	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Shared Care Plan (SCP)	CMT Pre-Manage ED & Pre-Manage SCP implementation – need DUA*	<span style="background-color: red; border: 1px solid black; padding: 2px;">R</span>
Direct Secure Messaging (DSM)	Kno2 DSM implementation	<span style="background-color: red; border: 1px solid black; padding: 2px;">R</span>
Closed Loop Referral System	Existing EHR System or via Kno2 or another third party vendor approved by IT Governance Committee	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>
Secure Data Storage & Internet Connection Capabilities	NIST review to access ability to secure PHI through technology and ability to securely connect to the internet	<span style="background-color: yellow; border: 1px solid black; padding: 2px;">Y</span>

\*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 Health Information Technology Implementation Status by Partner

Part of Phase/PH only	SPY 19 A2 Sub-Contract Execution	SAGE Introductions Completion	NIST Assessment Scheduled	CMT Introductions Completion	CMT Installation Complete	Kno2 Introductions Completion	Kno2 Contract Completion	MAeHC Reporting	HIPAA/42 CFR Part 2	Initial IDN HIT Intro Overview Date	Organization
3	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							HIPAA		American Medical Response (AMR)
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							HIPAA	12/12/18	Ascentria Care Alliance
3	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							Neither		Bridges
1	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							HIPAA	1/10/18	City of Nashua Department of Public Health
2	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							HIPAA		Courville Communities at Nashua
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: grey; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	already completed in 2018						HIPAA	10/24/18	Crochet Mountain
1	<span style="background-color: yellow; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: grey; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						42 CFR Providers		Dartmouth Hitchcock Nashua
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							42 CFR Providers	1/10/18	Emmaus Institute
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						42 CFR Providers	bi-weekly mtgs	Foundation Medical Center
2	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							Neither		Front Door Agency
1	<span style="background-color: yellow; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							HIPAA	10/23/18	Gateways Community Services
2	<span style="background-color: yellow; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							HIPAA	1/10/18	Granite State Independent Living (GSIL)
1	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						42 CFR	via Liaison	Greater Nashua Mental Health Center
2	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	already completed in 2018						HIPAA	1/13/18	Hillsborough County (Corrections and Nursing Facility)
2	<span style="background-color: yellow; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							Neither	1/11/18	Home Health and Hospice
1	<span style="background-color: yellow; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							42 CFR Providers		HEARTS Peer Support Center
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							42 CFR Providers		Laflore Psychological Associate
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						42 CFR Providers	bi-weekly mtgs	Lamprey Health
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							HIPAA	10/17/18	Life Coping
1	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							42 CFR		Merrimack River Medical Services
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	02/04/19						Neither	1/10/18	National Alliance for Mental Health (NAMI) NH
3	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						HIPAA		New Hampshire Hospital
1	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						42 CFR		Partnership for Successful Living
2	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							Neither		Revive Recovery Center
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						42 CFR Providers	bi-weekly mtgs	Southern NH Medical Center
2	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						Neither		Southern NH Services
2	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						Neither		St. Joseph Community Services
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	N/A						HIPAA	bi-weekly mtgs	St. Joseph Hospital Physician Practices
3	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							Neither		United Way of Greater Nashua
3	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: red; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							Neither	10/3/18	YMCA
1	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>	<span style="background-color: green; border: 1px solid black; border-radius: 50%; width: 10px; height: 10px; display: inline-block;"></span>							42 CFR	06/17/18	Youth Council



## IDN 3 DSRIP Demonstration Waiver B1: Integrated Health

Status: Week Ending: 1/11/19 **Y**

### Recent Accomplishments

1. CCSA implementation
2. Project level care coordination practices (stand-alone B1s and multi-provider B1s).
3. Clinical Committee review/approval of IDN 3 Policies & Procedures for CY 2018 annual measures and Lamprey's CCSA Tool

### Project Issues/Risks

**Issue:** Not meeting coordinated care practice designation by 12/31/18.  
**Result:** Not achieving competencies for coordinated care practice designation.  
**Issue:** Limited use of Maine SSA survey results to guide quality improvements of B1 practices & progress towards coordinated care practice designation.  
**Result:** Lack of improvement milestones in FY19 scope of services/implementation plans for B1.

### Mitigation to Risks

1. Jan-June 30, 2019 work plans to focus on coordinated care designation
2. Provider identify improvement milestones based on their last SSAs.
3. CCSA/CLR policy guides completed and ready to share with providers.
4. Use IDN4 guidelines for B1 interventions.

### Project Deliverables

Deliverable	Key Driver to Status	Status
Complete Jan-June 2019 coordinated care practice designation work plan.	B1 work plan for Jan-June 2019 SAR reporting	<b>R</b>
Standardized Self-Assessments	December 2018 SSA surveys submitted to UNH/CHI.	<b>R</b>
Universal Screening (CCSA)	All completed CCSAs submitted to MAeHC before Feb15, 2019	<b>Y</b>
Closed Loop Referrals Protocol	Workflows/ training under design but delayed	<b>Y</b>
Shared Care Plan	Under design	<b>R</b>
Multi-Disciplinary Core Team	Identified by some providers, but not in operation formally	<b>Y</b>
Monthly Case Management for Patients with Complex Health Needs	Not started/delayed	<b>N</b>

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 Integrated Health Implementation by Partner

Status: Week Ending: 1/11/19 **Y**

CCSA Tool Identified	CCSA Implementation & MAeHC Reporting	Information Sharing (ENS, CLR, SCP)	Multi-Disciplinary Team Identified	MDCT Monthly Case Management Meetings	Partner
<b>G</b>	<b>Y</b>	<b>Y</b>	<b>G</b>	<b>Y</b>	Dartmouth Hitchcock
<b>G</b>	<b>G</b>	<b>R</b>	<b>O</b>	<b>O</b>	Emmaus Institute
<b>G</b>	<b>G</b>	<b>R</b>	<b>G</b>	<b>Y</b>	Foundation Medical Partners
<b>Y</b>	<b>Y</b>	<b>Y</b>	<b>R</b>	<b>R</b>	Greater Nashua Mental Health Ctr
<b>Y</b>	<b>Y</b>	<b>Y</b>	<b>G</b>	<b>R</b>	GNMHC CTI
<b>Y</b>	<b>Y</b>	<b>Y</b>	<b>G</b>	<b>G</b>	GNMHC IDDT
<b>G</b>	<b>Y</b>	<b>R</b>	<b>G</b>	<b>G</b>	InteGreat Health
<b>G</b>	<b>Y</b>	<b>R</b>	<b>O</b>	<b>O</b>	LaMora Psychological Assoc
<b>G</b>	<b>Y</b>	<b>R</b>	<b>G</b>	<b>Y</b>	Lamprey Health
<b>R</b>	<b>R</b>	<b>R</b>	<b>O</b>	<b>O</b>	Merrimack River Medical
<b>R</b>	<b>R</b>	<b>R</b>	<b>R</b>	<b>R</b>	Partnership for Successful Living
<b>O</b>	<b>O</b>	<b>R</b>	<b>O</b>	<b>O</b>	St. Joseph Hospital
<b>R</b>	<b>R</b>	<b>R</b>	<b>R</b>	<b>R</b>	St. Joseph Physician Practices
<b>O</b>	<b>O</b>	<b>G</b>	<b>O</b>	<b>O</b>	Southern NH Medical Center
<b>G</b>	<b>G</b>	<b>R</b>	<b>O</b>	<b>O</b>	The Youth Council

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

### IDN Network Changes

During this reporting period the IDN officially gained a new partnership with LaMora Psychological Associates via completion of all appropriate documentation, participation in multiple foundational information meetings, review of subcontract documentation, partnership with MAeHC and engagement in CCSA training in preparation for implementation of the CCSA in Q1 2019.

Additionally the decision was made to remove New Hampshire Hospital from this reporting period updates due to the statewide review of their participation taking into consideration concerns with privacy of confidential data is still being addressed.

### **Community Input/Governance**

Community input is gathered in a number of different ways inclusive of the governance structure in place for IDN 3 due to the partner participation and engagement in all 5 governance committees (Executive, Finance, Clinical, Data/IT, and Community Engagement). In the prior reporting period the committees moved to a quarterly meeting cadence but with the time sensitivity of information and need for decision-making, the committees have migrated back to a monthly frequency. Additionally, an IDN Admin team member has been assigned to each committee with the purpose of supporting the committee chairs in their ability to lead and facilitate these important opportunities for dialogue.

#### *Full IDN Monthly meetings*

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 MAeHC data analysis, 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.

#### *Community Engagement and Education*

One of the key charges of the Community Engagement Committee is to support the City of Nashua Department of Public Health in their sponsorship of the Public Health Advisory Council (PHAC) Annual Meeting held each October. In addition to partnering on the development of the day’s events the IDN also strongly encourages IDN partner members to participate. This resulted in 20+ attendees and/or presenters as part of the conference.

Additionally, in December this committee made a decision to hold Wellness Dinner Focus Groups which will draw the community in for conversation and collect primary data (from stakeholders) about healthcare system function and access. The intent is to gather feedback from community stakeholders – including consumers, family/friends, caregivers, and providers – on the progress of the Transformation Waiver implementation, on areas of strength, and on areas that need further development.

### **Opioid Crisis Update**

Hillsborough County (of which IDN 3 contains 13 of the 31 towns) did not see improvement in drug-related incidents, including Narcan administration by EMS, opioid-related emergency department visits and treatment admissions, as can be seen below:

Hillsborough County Narcan incidents with EMS:

- 69 in January
- 81 in February
- 95 in March
- 81 in April
- 92 in May
- 69 in June

Opioid-related Emergency Department visits:

- 239 in January
- 174 in February
- 174 in March
- 161 in April
- 177 in May
- 151 in June

Opioid-related treatment admissions:

- 76 in January
- 57 in February
- 59 in March
- 53 in April
- 63 in May
- 85 in June

Nashua Safe Stations, a project of the Partnership for Successful Living (an IDN Member Entity), reported the following as of December 21, 2018:

- Number of requests for Nashua Safe Station: 2532
- Number of participants transported to hospitals: 269
- Average Length of Time Nashua Fire and Rescue (NRF) Company “Not Available”: 10.2 minutes
- Number of unique participants: 1443
- Number of repeat participants: 1375
- Age range of participants: 18-61

## **Project Plan Implementation (PPI) Budget**

The IDN completed its first year of sub-contracting with IDN Member Entities who were approved for funding to support their proposed strategies in July 2017. There was a determination made by the Admin Lead and Governance that all sub-contracting and subsequent funding would follow the state fiscal year (SFY), which began July 1, 2017 and ended June 30, 2018.

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, 2020. 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 – December 2018): \$669,855.95

- CY 17 (July 2017 – December 2017): \$46,922.00
- CY 18 (January 2018 – December 2018): \$622,933.95

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 – December 2018): \$257,917.34

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$257,917.34

\*does not reflect all invoices expected from all IDN Member Entities for the July – December 2018 time frame.

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 allocated to 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): \$303,213.62

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$303,213.52

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): \$78,580.18

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$78,580.18

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): \$80,257.87

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$80,257.87

\*does not reflect all invoices expected from all IDN Member Entities for the July – December 2018 time frame.

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): \$136,991.69

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$136,991.69

\*does not reflect all invoices expected from all IDN Member Entities for the July – December 2018 time frame.

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 30 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.

## IDN Project Plan Implementation Budget Table

PROJECT	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	Jan - June 2018 Actuals	July – Dec 2018 Projected	July - Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
A1	\$3,271,373.32	\$0.00	\$46,922.00	\$303,787.00	\$486,777.39	\$319,146.95	\$1,040,606.95	\$1,040,606.95	\$520,303.47	\$3,271,373.32
A2	\$1,972,046.44	\$0.00	\$0.00	\$128,524.00	\$307,253.74	\$129,393.34	\$685,651.64	\$685,651.64	\$342,825.82	\$1,972,046.44
B1	\$5,551,246.68	\$0.00	\$0.00	\$33,279.00	\$924,061.28	\$268,934.52	\$2,099,613.26	\$2,099,613.26	\$1,049,806.63	\$5,551,246.67
C1	\$788,231.90	\$0.00	\$0.00	\$46,188.00	\$123,673.98	\$32,392.18	\$283,860.69	\$283,860.69	\$141,930.34	\$788,231.90
D3	\$793,102.66	\$0.00	\$0.00	\$47,578.00	\$124,254.11	\$32,679.87	\$285,137.92	\$285,137.92	\$142,568.96	\$793,102.67
E4	\$617,257.00	\$0.00	\$0.00	\$81,926.00	\$89,221.83	\$55,065.69	\$192,106.12	\$192,106.12	\$96,056.06	\$617,259.99
Total	\$12,993,258.00	\$0.00	\$46,922.00	\$641,282.00	\$2,055,242.33	\$837,612.55	\$4,586,976.58	\$4,586,976.58	\$2,293,491.28	\$12,993,260.99

## 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 Plan Implementation (PPI): Attachments***

Attachment PPI.a.: Project Plan Implementation (PPI) Implementation Plan

Status	Task Name	Details	Start Date	End Date
Complete	I. Community input into IDN activities		11/01/16	06/29/18
Complete	A. Governance input on IDN 3 project implementation strategies and budget		11/01/16	06/29/18
Complete	A1. BH Workforce Capacity Building		02/01/17	06/29/18
Complete	Form Behavioral Health Workforce work team		02/01/17	05/31/18
Complete	Review/approval of proposed strategies and budgets by Governance Committees		07/20/17	06/29/18
Complete	Approve SFY 2019 Implementation Budget		03/01/18	06/29/18
Complete	A2. Health Information Technology (HIT)		11/01/16	06/29/18
Complete	Data/IT Governance Committee		11/01/16	06/15/17
Complete	Evaluate HIT platform vendors			
Complete	Approve Initial Project Implementation Budget		07/20/17	07/27/17
Complete	Approve SFY 2019 Implementation Budget		03/01/18	06/29/18
Complete	B1		04/03/17	06/29/18
Complete	RFP Process		04/03/17	06/15/17
Complete	Form Provider Integration Work Team			
Complete	Approve Initial Project Implementation Budget		07/20/17	07/27/17
Complete	Approve SFY 2019 Implementation Budget		03/01/18	06/29/18
Complete	C1		01/02/17	06/29/18
Complete	Clinical Governance Committee Work Team		01/02/17	06/15/17
Complete	Form CTI Work Team			
Complete	Approve Initial Project Implementation Budget		07/20/17	07/27/17
Complete	Approve SFY 2019 Implementation Budget		03/01/18	06/29/18
Complete	D3		01/02/17	06/29/18
Complete	Clinical Governance Committee Work Team		01/02/17	06/15/17
Complete	Form D3 Work Team			
Complete	Approve Initial Project Implementation Budget		07/20/17	07/27/17
Complete	Approve SFY 2019 Implementation Budget		03/01/18	06/29/18
Complete	E4		01/02/17	06/29/18
Complete	Clinical Governance Committee Work Team		01/02/17	06/15/17
Complete	Form E4 Work Team			
Complete	Approve Initial Project Implementation Budget		07/20/17	07/27/17
Complete	Approve SFY 2019 Implementation Budget		03/01/18	06/29/18
Complete	II. Network Development		01/12/17	11/15/18
Complete	Full IDN Meetings	At Least Quarterly	01/12/17	11/15/18
Complete	2017 Meetings		01/12/17	12/21/17
Complete	2018 Meetings		01/25/18	11/15/18
Complete	January 2018	Updates on statewide projects; Peer Support education (Revive Recovery and H.E.A.R.T.S.)	01/25/18	01/25/18
Complete	February 2018	Updates on statewide projects and overview of upcoming trainings	02/22/18	02/22/18
Complete	March 2018	Updates on statewide projects and Unpacking Assumptions: Cultural Competency training	03/23/18	03/23/18
Complete	April 2018	Updates on statewide projects and NH Healthy Families provider portal and patient analytics tools	04/26/18	04/26/18
Complete	May 2018	Commissioner Meyers shared how the State has been working closely with their federal colleagues to address CMS's concerns over the funding methodology, with discussion surrounding the process and the proposed resolution.	05/24/18	05/24/18
Complete	June 2018	Training on Co-Occurring Disorders, provided by NH Healthy Families	06/22/18	06/22/18
Complete	IDN presentations/workshops in the community		06/01/17	10/10/18
Complete	IDN 3 Behavioral Health Conference		06/01/17	10/10/18
Complete	October 2017		06/01/17	10/05/17
Complete	October 2018	scheduled for October 10, 2018	10/10/18	10/10/18
Complete	IDN Member Entities		10/26/17	03/19/18
Complete	United Way of Greater Nashua		10/26/17	10/26/17
Complete	Lamprey Health Staff Meeting		03/01/18	03/19/18
Complete	IDN 3 B1 Cherokee Health Kick-off Event		03/01/18	03/29/18
Complete	March 2018		03/01/18	03/29/18
Complete	IDN Career Fair		08/01/17	09/29/17
Complete	September 2017		08/01/17	09/29/17
Complete	III. Addressing the Opioid Crisis		06/01/16	12/31/20
Complete	Review of existing data on regional trends		06/01/16	01/01/20
Complete	Needs Assessment conducted		09/01/16	11/01/16
Complete	Project strategies identified		09/01/16	06/15/17
Complete	Project partners identified		09/01/16	11/15/17
Complete	Strategies implemented		11/30/17	12/31/20
Complete	IV. Governance		05/09/17	12/24/18
Complete	Inaugural Governance Committee Members start		07/10/17	12/18/18
Complete	Executive Governance Committee		07/17/17	12/17/18
Complete	2017 Meetings		07/17/17	11/20/17
Complete	2018 Meetings		01/15/18	12/17/18
Complete	Governance Committee Meeting	-DSRIP funding update -Sub-contracting updates -Updates on PSL status with IDN -New approved meeting structure for Governance (quarterly), Work Teams (monthly) and roles of Admin Lead Team B1 work teams	01/15/18	01/15/18
Complete	Governance Committee Meeting	-Compliance report update -Discussion re: changeover of Governance Committee membership -Updates on DSRIP funding	02/19/18	02/19/18
Complete	Governance Committee Meeting	cancelled to hold CCSA learning session	03/19/18	04/04/18
Complete	Governance Committee Meeting	-Vote on recommended committee chair and member change-overs for Governance Committees	05/21/18	05/21/18
Complete	Governance Committee Meeting	Cancelled	06/18/18	06/18/18
Complete	Finance Governance Committee		07/12/17	12/10/18
Complete	2017 Meetings		07/12/17	07/20/17
Complete	2018 Meetings		01/08/18	12/10/18
Complete	Governance Committee Meeting	-Updates on DSRIP funding -Contracts update (A1, A2) -Updates on PSL engagement in the IDN -Other business: workforce recruitment, hiring and retention conditions (re: sign-on bonuses and loan repayments)	01/08/18	01/08/18
Complete	Governance Committee Meeting	-E-vote on chair and membership for July 1 2018 to June 30 2020	04/09/18	04/09/18
Complete	Clinical Governance Committee		07/10/17	12/10/18
Complete	2017 Meetings		07/10/17	12/11/17
Complete	2018 Meetings		02/27/18	12/10/18
Complete	Governance Committee Meeting	e-vote on training topics and funding	02/27/18	02/27/18
Complete	Governance Committee Meeting	-Chair and membership discussion for July 1 2018 to June 30 2020	04/09/18	04/09/18
Complete	IT/Data Governance Committee		07/13/17	07/26/18
Complete	2017 Meetings		07/13/17	11/30/17
Complete	2018 Meetings		01/22/18	07/26/18
Complete	Governance Committee Meeting	-Sage NIST Cyber Security Assessment presentation -PatientLink overview (Patrick Ulmen) -Updates on flat file extracts and updated flat file template (MAeHC) -Work Team schedule discussion	01/22/18	01/22/18

attachment\_PPI.a  
DSRIP IDN Project Plan Implementation

Status	Task Name	Details	Start Date	End Date
Complete	Governance Committee Meeting	Members reviewed the working draft of the CCSA and discussed the following edits: oTo use a less combative/angry response i.e. changing I chose not to answer to I prefer not to answer. oClarify question 6 especially for students by providing examples of drugs such as marijuana, heroin, LSD etc. oCombining AUDIT C questions 7 and 8 (in the old tool) to one question 7 (in the new tool). oTo bring spirituality question back in the tool with the goal to strengthen social and emotional health screening (question 14) or by including spirituality counseling/case management as an interventions option in some domains care pathways. oAdding a question 22 - Do you want help with any of these issues?	04/26/18	04/26/18
Complete	Community Engagement Governance Committees		09/19/17	12/18/18
Complete	2017 Meetings		09/19/17	11/21/17
Complete	2018 Meetings		01/06/18	12/18/18
Complete	Governance Committee Meetings	-Review of IDN decision-making structure (Work Teams -> Governance Committees -> Executive Steering Committees) -Review of original CEC Work Teams (BH Conference, Social Media/Media Messaging, Training & Development, and Data Collection/Resources) -Identification of new work team structure: External/Community Trainings and Data Collection/Resources -Considerations based on future needs, including Social Media/Media Messaging and other work teams as needed	01/06/18	01/06/18
Complete	Governance Committee Meetings	October 10, 2018 BH Conference planning	04/17/18	04/17/18
Complete	Governance Committee Work Teams		05/09/17	12/24/18
Complete	Clinical Committee		05/09/17	12/24/18
Complete	CCSA/Universal Screening Work Team		05/11/17	12/13/18
Complete	2017 Meetings		05/11/17	09/20/17
Complete	2018 Meetings		01/11/18	12/13/18
Complete	Team Meeting	-Overview of team goals: make recommendations to Clinical Governance Committee and eventually Executive Committee re: CCSA tool and clinical workflows as well as referral workflows -Overview of CCSA domains -Determine IDN 3 screening questions for CCSA -Identify next steps	01/11/18	01/11/18
Complete	Team Meeting	-CCSA and referrals presentation: definitions, purpose, domains to be assessed and performance outcome metrics -Key questions for consideration re: CCSA and Referrals -Identify homework for key leaders from each IDN org responsible for implementing CCSA during an office visit -Identify next steps	02/08/18	02/08/18
Complete	Team Meeting	-DH SDOH pilot and BH Integration pilot overview as part of CCSA Learning Session	03/19/18	03/19/18
Complete	Team Meeting	-CCSA tool review and revisions	04/12/18	04/12/18
Complete	Team Meeting		05/10/18	05/10/18
Complete	Team Meeting		06/14/18	06/14/18
Complete	Information Sharing, Standardized Protocols and Workflows	Changed to Shared Care Plan and Case Management Work Team January 2018	05/09/17	12/24/18
Complete	2017 Meetings		05/09/17	05/09/17
Complete	2018 Meetings		02/26/18	12/24/18
Complete	Team Meeting	-Introductions -Overview of Community Care Team (CCT) in IDN 6 (Rockingham and Strafford County) with guest speaker, Tory Jennison -Determined need to learn more about the Nashua WRAP teams -Identify next steps	02/26/18	02/26/18
Complete	Team Meeting	Cancelled due to no quorum available	03/19/18	03/19/18
Complete	Team Meeting	Case Management/WRAP Model Training with DHHS Bureau of Children's Health, NFI North, Nashua Wrap-Around Team and GNMHC IDDT team	04/19/18	04/19/18
Complete	Team Meeting		05/28/18	05/28/18
Complete	Team Meeting		06/25/18	06/25/18
Complete	Statewide IDN Shared Care Plan Task Force	Objectives: -To consider a 'convention' or common approach to be used among IDNs for Shared Care Planning along with the evidence behind this common approach -To achieve consensus among and within IDNs for this convention and to refine the convention based on broad input -To open the discussion of the 'looming' shared care plan privacy questions and begin making key policy decisions -To inform the configuration of Shared Care Plan fields and access rules in vendor products -To lay the groundwork for IDNs to deploy shared care plans and to train users in their use	10/27/17	12/01/17
Complete	Webinar meeting #1	-Introduction to Draft Shared Care Plan Common Approach -Evidence to Support Common Approach	10/27/17	10/27/17
Complete	Webinar meeting #2		11/03/17	11/03/17
Complete	Webinar meeting #3		11/10/17	11/10/17
Complete	Consensus vote on core elements of SCP		12/01/17	12/01/17
Complete	Patient Consent and Privacy Work Team		05/24/17	03/20/18
Complete	2017 Meetings		05/24/17	10/17/17
Complete	2018 Meetings		03/13/18	03/20/18
Complete	UNH Law School 42 CFR Part 2 Training #1		03/13/18	03/13/18
Complete	UNH Law School 42 CFR Part 2 Training #2		03/20/18	03/20/18
Complete	Provider Practice Integration Work Team		05/15/17	06/13/18
Complete	Baseline Integrated Practice Site Self-Assessment (SSA)		05/15/17	06/16/17
Complete	December 2017 6-month follow-up SSA	Open period for completion: December 1, 2017 to January 15, 2018	11/30/17	01/08/18
Complete	June 2018 6-month follow-up SSA	Open period for completion: June 1 - 22, 2018 (telling practices deadline is June 15th, but allowing for additional time, if needed)	05/01/18	06/13/18
Complete	Emails sent to practice managers to let them know about SSA timeline		05/01/18	05/15/18
Complete	CMOs/clinical leaders send email to practice managers to complete SSA		06/01/18	06/01/18
Complete	Email reminder send to practice managers		06/11/18	06/11/18
Complete	Individual calls to practice managers who have not submitted completed SSA		06/13/18	06/13/18
Complete	Internal Provider and Workforce Training Work Team		02/12/18	12/10/18
Complete	2018 Meetings		02/12/18	02/12/18
Complete	Team Meeting	1. Background on provider and workforce trainings in IDN implementation plan 2. Review of initial proposed trainings: *Cultural Competency and Adaptation (Unpacking Assumptions and Stigma and Crossing Cultures) *Understanding Addiction (Initial Training on Addiction and Families and Addiction) *Care Planning and Care Coordination (Motivational Interviewing and CRSW training, including motivational interviewing, recovery training, suicide prevention) *Mental Health First Aid (Adults, Youth, and Train-the-Trainer through funding provided by Change Direction in April) *Patient Consent and Privacy (HIPAA/Secure Data Storage) 3. Discussion related to: *time of day/day of week *costs *target audience and location (including practice-based trainings, Grand Rounds, and community-based locations) 4. Next steps: email to Clinical Governance Committee with recommendations for initial trainings to be scheduled and implemented	02/12/18	02/12/18
Complete	Team Meeting	-E-vote on training items to recommend to Clinical Committee	03/12/18	03/12/18
Complete	Team Meeting	Clinical Governance Committee meets, so no work team meeting	04/09/18	04/09/18
Complete	Team Meeting	Phone meeting to review goals for upcoming SSA	05/14/18	05/14/18
Complete	Team Meeting	Cancelled	06/11/18	06/11/18
Complete	Clinical/HIT Combo		09/11/17	10/26/17
Complete	Health Integration Technology (HIT) Implementation to Support Integration		09/11/17	10/26/17
Complete	2017 Meetings		09/11/17	10/26/17
Complete	2018 Meetings	No meetings scheduled until fall 2018	06/30/17	12/31/18
Complete	Performance Metrics and Quality Monitoring		6/30/2017	12/31/2018
Complete	2018 Meetings	No meetings scheduled until fall 2018	06/30/17	12/31/18
Complete	Reporting Tools and Data Analysis		6/30/2017	12/31/2018
Complete	2018 Meetings	No meetings scheduled until fall 2018	06/30/17	12/31/18

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

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

#### **Progress on Key Milestones/Activities**

See attachment\_A1.3a for the Workforce Capacity Building Implementation Plan

Since the last reporting period, the IDN has reviewed its format/structure for reporting against staffing targets, determining it should streamline those targets by broad provider categories. As can be seen in the A1-5 Staffing Targets table, these broad provider categories have allowed for greater ease in internally tracking the individual positions targeted for on-boarding by IDN Member Entity, as many of the roles outlined entail various titles and education levels, depending upon the provider organization.

In addition, the A1-5 Staffing Targets table reflects a change in the 6/30/17 baseline numbers reflect actual individuals/positions in place at the onset of the IDN sub-contracts with its partners. For the most part, the baselines are 0 for that time frame, with each subsequent reporting period demonstrating actual progress in meeting targets.

#### **Workforce: Recruitment/Hiring and Retention**

##### *Progress*

IDN 3 provider organizations have had varied successes and challenges in the hiring/retention of IDN-funded positions and their workforce overall. The well-known workforce shortages have not eased up and no single solution has proven to mitigate the challenges they continue to experience. In support, IDN 3 has allotted partner funding for salaries, salary adjustments, benefits, professional development, professional dues/licensing fees and multiple workforce-related bonus types (sign-on, retention, referral, etc.). Several partners have taken advantage of this funding and those monies, and combined with other efforts, these have led to successes in their hiring/retention efforts as of the last half of 2018:

- NAMI:
  - o Family Education & Peer Support Specialist hired/retained since July 2018
- InteGreat Health (Lamprey/GNMHC partnership):
  - o Care Coordinator hired/retained since May, 2017
- The Youth Council:
  - o 2 Project IMPACT pilot project Master's Level Student Assistance Counselors are in their second year of employment at The Youth Council, **both receiving supervision toward licensure through IDN funds, as well as student loan repayment**
  - o An MLADC began with The Youth Council during this reporting period, addressing gap in therapists for adolescents
- GNMHC:

- Leveraged sign-on bonuses for Psychiatric Mental Health Nurse Practitioner, 3 therapists, 2 case managers
- **Leveraged Recruitment Agency/Fees to support the recruitment and hiring of a child psychiatrist as part of 29 clinical staff on-boarded during the reporting period**
- Leveraged **IDN allocations to support** HR staffing efforts in the continued recruitment of ~~both~~ an adult psychiatrist **and other positions supporting the IDN strategies**
- **Leveraged IDN Supervision Stipends to support 6 staff working toward MLADC and 8 staff working toward LICSW/LMFT**
- **Leveraged IDN Staff Recognition funds for 7 staff**
- **Leveraged CMEs/Professional Development funds for 22 staff and License Fees/Professional Dues for 1 staff**
- **Leveraged IDN funds for Employee Incentives/Retention Bonuses for 3 staff**
- Lamprey Health:
  - Leveraged sign-on bonus for an MSW/LICSW (also provided an IDN-funded salary adjustment to LICSW)
  - Leveraged HR staffing efforts in support of their new **Licensed Mental Health Counselor (LMHC)** and continue to leverage in their search for a CHW and Nurse Practitioner (NP)
  - Provided IDN-funded referral bonuses for the hiring of LICSW & LCMHC

Telehealth has been a solution to workforce shortages that several partners have been engaged in varying from requests for funding to initiate full scale evaluations to actual implementation of telepsychiatry solutions.

- Gateways Community Services has submitted a funding request with a detailed plan laid out in initiating telehealth for their developmentally challenged population.
- Crotched Mountain has a telehealth solution they are piloting in-house between social workers and RN's and are looking to expand to meet broader needs in the community by actually connecting with their clients virtually.
- Lamprey Health is launching a behavioral health telehealth approach and is planning on launching by June.
- Greater Nashua Mental Health implemented a telepsych program with a virtual med provider sitting in NY who routinely meets with their clients via a conference room in their NH location.

In addition, an IDN 3 project manager was identified as the Recruitment & Hiring subcommittee chair for the Statewide Workforce Taskforce this reporting period. During that time progress was made with the statewide group:

- a subcommittee was identified with representation from four of the seven regions and a representative from Bi-State Primary Care
- the Recruitment & Hiring work plan was refreshed, recommended edits were made and approved by the workforce taskforce, and progress was made on the following items:
  - engagement with AHEC to influence their job catalog currently under revision, to consider integrated healthcare roles;

- participation in cross-state discussions on care extender possibilities with occupational therapist and paramedicine roles to identify programs that are viable to consider publicizing more broadly

### ***Barriers and Mitigation Plans to Future Achievement***

IDN-funding has proven to help, but not solve, these partner organization workforce challenges with recruiting, hiring, and in some cases retaining roles, ranging from Community Health Workers to Psychiatrists. **While there was not one common barrier/issue among those IDN partners expected to build workforce capacity to engage in the IDN goals, there were some common themes that can be outlined to provide background for lack of achievement in onboarding to meet IDN-identified staffing targets outlined in the A1-5 Staffing Targets table.**

To broadly mitigate the issues/barriers identified below, the IDN has instituted several new ways of interacting and sharing information with its Member Entity partners.

These efforts include:

- **initiating the IDN *Partner Liaison* model, which entails having a member of the Admin Lead team assigned to each IDN Member Entity. As part of this model, the Liaison:**
  - **built a work plan with concrete deliverables and associated milestones and timelines to support their assigned provider partner in movement toward achievement of deliverables by the end of the next reporting period (June 2019).**
    - **These work plans encompass the major deliverables for each partner, as well as the process and outcome targets set for their individual strategies in their annual IDN sub-contract Scope of Work.**
  - **meets monthly with each partner to identify issues/barriers to achievement and supports them as they implement mitigation plans to address the issues/barriers.**
- **developing and sharing dashboards with all of the Governance Committees at their monthly meetings, as well as with all IDN Member Entities at the Full IDN monthly meetings. These dashboards:**
  - **provide insights into the key deliverables for each statewide project (A1, A2, and B1) and filter up to an Executive Summary dashboard that provides an overview of how the IDN is progressing overall.**
  - **include accomplishments since the previous month, the risk/issues and IDN (and partner) mitigations to address them, and color-coded status for each key deliverable, ranging from:**
    - **gray (not started) to**
    - **red (major issues/critical path at risk) to**
    - **yellow (minor issues/critical path recovery feasible) to**
    - **green (on track).**

Following is an overview of the issues and mitigation plans to achieve success in meeting key deliverables by the end of the next reporting period.

**Lack of qualified/experienced applicants**

- **Lamprey Health:**
  - **Community Health Worker (.71 FTEs):** the position has been posted on multiple professional job boards, as well as advertised through sponsored ads on recruitment sites with few resumes received and for those received, candidates did not have the relevant skills and experience needed.
    - **Mitigation:** Lamprey will use IDN hiring/recruitment incentive funds in addition to continuing to use sponsored ads and professional job boards to solicit qualified applicants.
  - **Consulting Pharmacist (.2 FTEs):** this position/role has not been currently on-boarded due to capacity issues.
    - **Lamprey plans to engage the on-site Genoa Pharmacy in exploring filling this role in early 2019.**

#### **IDN sub-contracting and DSRIP funding uncertainties**

Given the ongoing funding uncertainties with county matching contributions, several of the partners have expressed concern with moving forward with SFY '19 IDN sub-contracts and/or on-boarding staff. While this was not the sole reason for unexecuted IDN sub-contracts, the partners below have indicated it was a mitigating factor in moving forward with formal contracting.

- **Partnership for Successful Living (umbrella organization for Harbor Homes, Healthy at Home Keystone Hall):**
  - **Issues:** concerns about data sharing and Scope of Work changes from 2017 approved proposals/budgets impacting on-boarding of their Psychiatrist (.03 FTEs), Psychiatric APRN (.5 FTEs), Psychiatric Certified Nurse (1 FTE), RNs (1.2 FTEs detox and non-detox RNs), Case Managers (3 Integrated Care Case Managers), Community Health Worker (1 FTE), and IT/Data Analyst (.5 FTEs). Additionally, with no sub-contract, supervision stipends were not in place to support the 8 LADCs in moving toward becoming MLADCs.
    - **Mitigation:** continue working closely with PSL through IDN Partner Liaison model implemented during reporting period, supporting their revisions to their SOW and Governance approval, as well as their data sharing/legal concerns, with target sub-contract execution expected by March 2019
- **Merrimack River Medical Services:**
  - **Issues:** need for buy-in from BayMark, the national corporation which bought MRMS sites in NH impacting on-boarding of their Psychiatrist (.5 FTEs) and Behavioral Health Coordinator (1 FTEs).
    - **Mitigation:** continue working closely with MRMS and BayMark to educate them and determine their capacity to engage in the IDN, with the goal of achieving a decision about moving forward by March 2019
- **St. Joseph Hospital and Physician Practices:**
  - **Issues:** concerns about capacity due to merger with Covenant Health and migration to new EHR impacting on-boarding of their Psychiatrists (.5 FTEs adult and .2 FTEs pediatric), Behavioral Health Clinician/Specialist (1 FTE adult and .6 FTEs pediatric), Care Coordinator (.5 FTEs) and IT/Data Analyst (.5 FTEs).
    - **Mitigation:** continue working closely with SJH through IDN Partner Liaison model implemented during reporting period, strategizing on use of funding allocations to support additional staffing capacity needed to achieve deliverables, with target sub-contract execution expected by March 2019

## Partner decision-making for expending IDN-approved project funds

- **Foundation Medical Partners:**
  - **Issues:** concerns about use of IDN funding to support limited capacity needed to achieve deliverables resulting in their decision not to accept IDN funding allocations, other than A2: HIT to support MAeHC reporting and meeting minimum HIT capabilities/standards. This has impacted the IDN's staffing targets associated with FMP, including: Psychiatrist (.03 FTEs adult and .03 FTEs pediatric), Psychiatric APRN (.8 FTEs), Behavioral Health Clinician (2 FTEs), Behavioral Health Coordinator (1 FTE), and Receptionist (1 FTE).
    - **Mitigation:** support achievement of IDN deliverables through training and guidance in how to build internal capacity and changes in workflows to allow the organization to engage in activities necessary for their attributed population and information sharing among providers through IDN Partner Liaison model implemented during reporting period
- **GNMH:**
  - **Issue:** CTI: determination to wait to on-board the CTI Specialist (.5 FTE Case Manager) while learning more about how operationalization of the CTI program will evolve
  - **Issue:** D3 Weekly Community-Based Pre-Treatment Groups: determination to wait to on-board the co-facilitator roles (Peer Support Specialist: .03 FTE and Licensed Therapist: .03 FTE) due to challenges in securing long-term location for groups

## Staff turnover

- **GNMH:**
  - **IDDT issues and mitigation plan:**
    - Psychiatrist (.5 FTE) left position in late June 2018, and has been replaced temporarily by existing in-house Psychiatrist;
    - Nurse (.5 FTE) left position in September 2018, and was replaced by existing in-house Nurse
    - Team Lead (1 FTE Licensed Therapist) left position in September 2018, but an existing IDDT team member (therapist) was able to be on-boarded and overlap with them for a few weeks to ensure a seamless transition
    - Licensed Therapist (1 FTE) was on-boarded to replace therapist moving to Team Lead role in October 2018
    - Supportive Employment Specialist (.5 FTE) left position in late December 2018 to move to Texas
      - **Mitigation:** GNMH is contracting with a Website Design Consultant through the use of IDN funds to provide improvements to the organization's webpage to create a more integrated online application process to streamline the process for both applicants and HR.
  - **Intern retention issues and mitigation plan:**
    - Master's Level Intern (1 FTE BH Clinician/Specialist) , as part of Internship Cohort developed through a partnership between The Youth Council and GNMHC, left role in October 2018 for a new opportunity
      - **Mitigation:** Better understand what incentives could support onboarding interns and/or Master's Level positions through GNMH contracting with a *Compensation Analyst Consultant* with the use of IDN

**funds. This consultant will provide an analysis of comparable organizations regarding compensation/incentive programs and provide suggestions for how to attract and retain staff.**

- **The Youth Council:**
  - **Issue: Master’s Level Intern (1 FTE BH Clinician/Specialist), as part of Internship Cohort developed through a partnership between The Youth Council and GNMHC, left role in October 2018 for new opportunity.**
    - **Mitigation: investigate student loan repayment opportunities and other incentives to entice interns to work with the organization while building their skills and then use those incentives to potentially hire the students.**

### **Reciprocal licensing challenges**

- **Lamprey Health:**
  - **Issue: Hired an MSW in November ’18 and will need to continue to engage them in onboarding until May ’19 due to ~~experienced~~ a very lengthy and frustrating process with the NH Board of Mental Health because license reciprocity from Massachusetts still not in place, **even though they had been working in MA in a similar capacity for over 9 years.** As a result, the candidate was required to complete additional coursework to receive NH license ~~(had been working in Mass in similar capacity for over 9 years).~~**

In support of the workforce shortages faced by IDN3 partners, telehealth appears to have incredible opportunities once the barriers of funding (anticipated to be supported once the county funding outcome is known), reimbursement and billing limitations (statewide workforce taskforce policy subcommittee working on with the Legislature), and cross state line healthcare support are worked out.

Note: Decision made to remove New Hampshire Hospital from the table of Key Organizational and Provider Participants table due to the statewide review of their participation taking into consideration concerns with privacy of confidential data is still being addressed.

### **Workforce: Training and Education**

#### *Progress*

Having sponsored a total of 24 trainings during the July-Dec ’18 reporting period (see tables below: 5 technology-related, 19 integrated health-related trainings), IDN 3 provided numerous opportunities for community partners to engage in educational development. These trainings varied in length, location, audience targeted and content focus. Several trainings were held onsite at provider locations in support of ease of access for full staff participation and others were held in easily accessible community locations (Nashua Public Library, United Way of Greater Nashua, etc.). Additionally, several community partners (Greater Nashua Mental Health, Dartmouth Hitchcock, Southern NH Medical Center, etc.) opened their doors to the full IDN membership to attend trainings at their locations.

In addition to IDN 3 sponsored trainings, the IDN advocated partner membership participation in several other organizations’ sponsored events, at times even funding fees associated to registration. These additional development opportunities included:

- ~~monthly Myers & Stauffer~~ B1 Integration Leads Learning Collaborative meetings
- ~~the Myers & Stauffer~~ quarterly Learning Collaborative meetings

- the NH Behavioral Health Summit held in December (21 IDN3 sponsored attendees)
- Greater Nashua Public Health Advisory Council Annual Meeting held in October (26 IDN 3 partner attendees) which continues to be heavily supported by the IDN 3 Community Engagement Committee.

**Barriers and Mitigation Plans to Future Achievement**

Although most of the IDN 3 offered trainings were focused on those required for the multi-disciplinary core team, all IDN partner members were encouraged to participate due to the relevant content areas for most in the primary and behavioral health clinical space. In many cases this resulted in strong participation levels, although not necessarily by multi-disciplinary core team members. The relatively low attendance by the core team members was evident with partner feedback reinforcing the challenge of losing billable clinical time. The loss was exacerbated both due to the length of the trainings offered (several were 8 hours in length) as well as travel time, even if within the Greater Nashua area.

In response to the training barriers, IDN 3 has revamped our training approach. Beginning in January '19, we will:

- provide a more diverse delivery format for training opportunities by:
  - incorporating shorter trainings (1-2 hours in length) and
  - ~~implementing~~ **providing access to** more webinars and self-paced development opportunities.
- **leverage organization’s existing internal training as well as individual provider’s professional development opportunities and licensing requirements to leverage meeting required training content.**
- exploring ideas to incentivize training participation by engaging with other IDNs to learn more about strategies they’ve incorporated to achieve training requirements for MDCT members.

**Finally, through the newly instituted IDN Partner Liaison role and monthly meetings, in addition to monthly reporting on achievement of target deliverables, we expect significant achievement for MDCT and non-direct care staff training by the end of the next reporting period.**

Multi-Disciplinary Team Required Training			
Category	Training	Learning Objectives	Held
CCSA/Universal Screening			
	CCSA/Universal Screening	<ul style="list-style-type: none"> <li>• Review IDN protocols/policies for completed CCSA process</li> <li>• Review organizational CCSA process workflows and staff roles and responsibilities</li> <li>• Address concerns/barriers</li> </ul>	8/23/18 11/7/18 11/29/18
Care Planning/Care Coordination			
	Advanced Motivational Interviewing	<ul style="list-style-type: none"> <li>• Discuss motivation as it pertains to their own clients.</li> <li>• Employ several techniques to develop discrepancy between goals and current behavior.</li> <li>• Use strategies to explore, amplify, and resolve ambivalence to change.</li> <li>• Demonstrate the ability to elicit, recognize and reinforce change talk.</li> <li>• Differentiate and practice simple and complex reflections.</li> <li>• Describe how MI can be integrated into current practice.</li> </ul>	7/30/18

	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	10/4/18
<b>Co-Occurring Disorders</b>			
	Intersection of Chronic Disease/BH	<ul style="list-style-type: none"> <li>Define the latest guidelines for diabetes, hypertension and dyslipidemia</li> <li>Understand the intersection of behavioral health and chronic disease management</li> <li>Identify barriers to the integration of behavioral health care and chronic disease management</li> <li>Identify and utilize strategies to overcome identified barriers</li> </ul>	10/31/18 12/12/18
<b>Mental Health First Aid</b>			
	Adult MHFA	<ul style="list-style-type: none"> <li>A 5-step action plan to help a person in crisis connect with professional, peer, social, and self-help care</li> <li>Topics covered include anxiety, depression, psychosis, and addictions, with the focus on those 18 years of age and older.</li> <li>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.</li> </ul>	11/5/18 12/3/18
<b>Cultural Competency</b>			
	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.	9/12/18 9/24/18 10/18/18 12/5/18
	Stigma Across Cultures	<p>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.</p> <ul style="list-style-type: none"> <li>Identify three or more demographic groups and at least one way in which each group has experienced difficulty approaching MH or SUD services</li> <li>Discuss impact of societal stigma and stereotyping on MH and SUD clients</li> <li>Apply best practices using client cases</li> </ul>	11/2/18
	Ethics & Cultural Competency Skills	<ul style="list-style-type: none"> <li>To be able to explain why ethics matters.</li> <li>To be able state at least 3 principles and virtues as an overall guide to the ethical decision behavior / rationality in all professions.</li> <li>To be able to recognize obstacles to ethical decision making.</li> </ul>	7/10/18 7/18/18 7/26/18 8/14/18 8/15/18

<b>Enabling Technology Training</b>			
<b>Category</b>	<b>Training</b>	<b>Participating Organization</b>	<b>Held</b>
<b>Collective Medical Technologies</b>			
	Pre-Manage ED - (transmittal to Event Notification Systems & basic Shared Care Plan noting)	<ul style="list-style-type: none"> <li>Southern NH Health</li> </ul>	9/12/18
	Overview/training of Shared Care Plan	<ul style="list-style-type: none"> <li>IDN 3 Project Team</li> </ul>	11/7/18

	Phase II Training - how Pre-Manage (ambulatory) can be used based on capabilities of Pre-Manage ED	<ul style="list-style-type: none"> <li>• Southern NH Health</li> </ul>	11/28/18
<b>MAeHC Manual Entry Portal Training</b>			
	Provider partner level “how-to” use and operationalize MAeHC manual entry	<ul style="list-style-type: none"> <li>• The Emmaus Institute</li> <li>• The Youth Council</li> </ul>	11/28/18 11/29/18

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress Not Met: This initiative will begin in spring 2018.	Progress Met: Contacts were made with Rivier University, University of New Hampshire and Boston University.	Achieved: Achieved in prior reporting period, <del>(6/18)</del> <b>through outreach with contacts made with Rivier University, University of New Hampshire and Boston University</b>
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.	Progress Not Met: This initiative will begin in late summer/early fall 2018.	Progress met: Two interns from Rivier University have been accepted to work with The Youth Council, with Greater Nashua Mental Health Center finalizing their recruitment efforts.	Achieved: Both The Youth Council and GNMHC initiated opportunities resulting in employment of 2 interns each (4 total) with each retaining <b>1 intern each</b> (2 total) <del>by 12/31/18</del>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress Met: 70 individuals RSVP'd and/or attended the Career Fair	In Progress: IDN partners continued to utilize the IDN's Career Board and overall website as a landing place for sending organizations and educational institutions. Lamprey and GNMHC worked with Rivier University to host the InteGreat Health kick-off event with Cherokee Health in March 2018, inviting Rivier students and faculty. Conversations are in progress with the IDN governance to host another career fair this fall, potentially at Rivier University.	Achieved: Achieved in prior reporting period, <del>with 412/17:</del> 70 individuals <b>who</b> RSVP'd and/or attended the 2017 Career Fair
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.	Progress Met: 37 resumes were received via the website and from the Career Fair	Progress Met: Qualified applicants submitted resumes to The Youth Council, GNMHC, Lamprey Health and Southern NH Health for positions related to the work of the IDN.	Achieved: Achieved in prior reporting period, with <del>(12/17:</del> 37 resumes <del>were</del> received via the <b>IDN 3</b> website and <del>from</del> the <b>IDN 3</b> Career Fair
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.	In Progress: IDN member organizations had numerous calls and interviews resulting from the Career Fair, but none resulted in hiring directly from the event. The IDN will continue to work with partners to keep the Career Board positions updated and may conduct other recruitment events to engage potential workforce members in 2018.	Positions have been filled at GNMHC, Lamprey Health, The Youth Council, Southern NH Health, and InteGreat Health.	<b>Achieved:</b> <b>Positions filled at Dartmouth Hitchcock, Greater Nashua Mental Health Harbor Homes, Lamprey Health, NAMI NH, and The Youth Council</b>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress Not Met: No sub-contracts for these activities were executed during the reporting period, yet efforts were undertaken with IDN organizations to support recruitment efforts. Sub-contracts are expected to be executed in early 2018, with invoices submitted to be reimbursed for these activities at that time.	Progress met: IDN funds (\$1,500) were utilized to support fees for recruitment sites.	<b>Achieved:</b> <del>2 member entities were allocated IDN recruitment funds neither resulting in actual positions hired</del> <b>IDN funds have been utilized to support dues/fees for recruitment efforts, resulting in successfully onboarding more than 6 positions.</b>
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.	Progress Not Met: No sub-contracts for these activities were executed during the reporting period, yet efforts were undertaken with IDN organizations to support recruitment efforts. Sub-contracts are expected to be executed in early 2018, with invoices submitted to be reimbursed for these activities at that time.	Progress Met: IDN funds were utilized for a staff stay incentive/retention bonus (\$2,500) for an MSW/LICSW and a one-time salary adjustment (\$7,000) for an MSW/LICSW staff member.	Achieved: <del>GNMNH 2 member entities were allocated IDN sign-on bonuses to 9 newly hired staff funds resulting in new hires</del>
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.	In Progress: No sub-contracts for these activities were executed during the reporting period, yet submitted job descriptions to the IDN to include as part of the Career Fair and on the Career Board to support recruitment efforts. Sub-contracts are expected to be executed in early 2018, with invoices submitted to be reimbursed for these activities at that time.	Progress Met: IDN funds (approximately \$1,700) were utilized to support HR staff in developing job descriptions and interviewing/onboarding staff, with several positions in the process of being filled.	Achieved: 2 member entities leveraged IDN HR-staffing support dollars resulting in new hires

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress Not Met: No sub-contracts for these activities were executed during the reporting period, yet efforts were undertaken with IDN organizations to support recruitment efforts. Sub-contracts are expected to be executed in early 2018, with invoices submitted to be reimbursed for these activities at that time.	Progress Not Met: No funds were utilized during the reporting period to support reimbursement of relocation expenses, but funds are expected to be allocated through GNMHC's efforts when they submit their final invoicing of expenses for the reporting period.	Not Achieved: No member entities utilized IDN-funded relocation funds resulting in hires, <b>however the GNMH 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.</b>
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.	Progress Not Met: No sub-contracts for these activities were executed during the reporting period, yet efforts were undertaken with IDN organizations to support recruitment efforts. Sub-contracts are expected to be executed in early 2018, with invoices submitted to be reimbursed for these activities at that time.	Progress Met: IDN funds (\$1000) were utilized to support staff referrals during the reporting period.	Achieved: <del>1 member entity was</del> <b>GNMH</b> allocated IDN referral bonus funds resulting in 2 new hires

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	In Progress: Sub-contracts were in process with GNMHC to support these supervisor stipends, which are expected to be executed in early 2018. The CEO of Harbor Homes and Keystone Hall shared with the IDN Admin Lead in December 2018 that they had experienced changes in their leadership in the fall 2018. They indicated they would be ready to re-engage in the IDN in early-mid 2018.	In Progress: 4 LADCs are being supervised by GNMHC.	Achieved: <del>Achieved in prior reporting period (12/17: 4 LADCs were being supervised by GNMHC)</del> 1 LADC being supervised by The Youth Council. <b>GNMH received supervision stipends for supervising 6 LADCs working toward becoming an MLADC</b>
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.	In Progress: GNMHC is in the process of finalizing sub-contracts with the IDN and is providing supervision to LADCs.	In Progress: the LADCs being supervised by GNMHC continue to be supervised.	Achieved <del>Achieved in prior reporting period (12/17: 4 LADCs were being supervised by GNMHC)</del> <b>GNMH on-boarded one MLADC who had been supervised as LADCs</b>
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.	Progress Not Met: No sub-contracts for these activities were executed during the reporting period, yet efforts were undertaken with IDN organizations to support workforce retention and sustainability. It is expected that sub-contracts will be executed in early 2018, with invoices for reimbursement for some of these activities to be submitted.	Progress Met: Ascentria Care Alliance (2 staff), NAMI (1 staff), Gateways Community Services (3 staff), and Lamprey Health (1 staff) utilized IDN funds for professional development/CMEs.	Achieved: <del>Achieved in prior reporting period, with (12/17: 7 staff utilized funding for professional development)</del> <b>GNMH provided CMEs/professional development funds to 22 staff and licensing fees and/or professional dues to 1 staff during the reporting period</b>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress Not Met: No sub-contracts for these activities were executed during the reporting period, yet efforts were undertaken with IDN organizations to support workforce retention and sustainability. It is expected that sub-contracts will be executed in early 2018, with invoices for reimbursement for some of these activities to be submitted.	Progress Met: IDN funds (\$2650) were utilized to support professional dues/licensing fees as well as \$15,000 to support student loan repayments for 3 Master's Level Counselors.	<b>Achieved:</b> <del>Other than Lamprey Health, no additional member entities utilized IDN-funded professional dues/licensing fee funds resulting in retention of staff for 24 months</del> <b>IDN funds have been utilized for 15 staff, with many of them having been retained in their positions since receiving these incentives.</b>
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.	Progress Met: 105 participants participated in October 2017 conference	In progress: 2018 BH Conference is being planning by the IDN Community Engagement Committee and is scheduled for October 2018, as part of the Nashua Public Health Advisory Committee Annual Meeting.	Achieved: 76 community members attended the 10/10/18 the Greater Nashua Public Health Advisory Council Annual Meeting, <b>which was co-hosted by the IDN as its annual behavioral health conference</b>
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	In Progress: Training plans are identified, with training to begin in early 2018.	Progress Met: 17 IDN Member entity providers were trained in Mental Health First Aid.	Achieved: Two Mental Health First Aid trainings were held/ attended by 27 participants: - 12/3/18 (17 participants) - 11/5/18 (10 participants)

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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).	Progress Met: More than 8 providers participated in the December 2017 2-day training conducted by Case Western Reserve University	In progress: The IDDT team has had significant staffing turnover, including the Team Coordinator/Lead, so the training on the first two stages of change/treatment will be provided to the full team in September 2018, with the remaining two stages of change/treatment training provided late in 2018 or early 2019.	<b>Achieved:</b> Achieved in prior reporting period (12/17: More than 8 providers participated in the December 2017 2-day training conducted by Case Western Reserve University) <b>All members of the IDDT team participated in the Stages 1 and 2 training provided by Case Western Reserve University in September 2019</b>
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.	Progress Met: 10 providers participated in the November 2017 CTI Staff training conducted by Hunter College	Progress Met: 2 CTI team members participated in the March 2018 CTI Staff Training.	Achieved: Achieved in prior reporting period, with <del>(12/17: 12</del> providers participating <del>ed</del> in the November 2017 <b>and March 2018</b> CTI Staff training conducted by Hunter College

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

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
Psychiatrist/Psychiatric Advanced Practice Registered Nurse (APRN)	12.5	11	11	11	11
Psychiatrist for IDDT	0.5	3	3	3.5	3.5
Psychiatric Certified Nurse	1	0	0	0	0
Consulting Psychiatrist	0.2	3	3	3.2	3.2

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
Physician's Assistant (Certified)	0.2	6	6	6.2	6.2
Registered Nurse (Associate's Level)	3.5	73	73	73.5	73.5
Consulting Pharmacist	0.1	20	20	20.1	20.1
Licensed Pastoral Psychotherapist	0.75	2	2	2.75	2.75
<b>Mental Health Counselor (Psy.D.)</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
<b>Mental Health Counselor (MLADC)</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
Mental Health Counselor (Master's Level LMHC/LICSW)	10	85	85	92	91
Counselor Under Supervision (Master's Level)	15	2	4	10	12
LADC working toward MLADC under supervision (Substance Use Counselor)	12	18	18	22	23
Behavioral Health Clinician/Specialist (Master's)	5	5	5	6	6
<b>Clinical Case Manager</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>
Behavioral Health Case Manager (Bachelor's)	8	12	12	17.5	16
Behavioral Health Coordinator (Bachelor's)	5	63	63	63	63
Case Manager (RN Bachelor's Level)	1.7	90.6	90.6	90.6	90.6
Clinical Operations	<del>2</del>	9	9	<b>9.2</b>	<b>9.2</b>
Master's Level Substance Use Disorder Therapist	1	16	17	17	17
Clinical Care Coordinator (Master's)	.5	6	6	6.5	6.5
Clinical Care Coordinator (RN Associate's)	0.5	70.6	70.6	70.6	70.6
SUD Transitional/Recovery Care Coordinator	1	0.5	0.5	.5	1
Criminal Justice Specialist/Liaison	0.1	6	6	6.1	6.1
Supportive Employment Specialist	0.5	11	11	11.5	11
Housing Specialist	0.1	3	3	3.1	3.1
Family Specialist	0.1	6	6	6.1	6.1
Community Health Worker	8	40	40	44	44
Family Education and Peer Specialist	1	14	15	15	15
Peer Support Specialist	1	30	30	30	30
Training Coordinator	0.5	7	7.5	7.5	7.5
DSRIP Integrated Health Project Manager	1	0	2	2	2
DSRIP Quality Improvement Manager	1	0	0	0	0

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
DSRIP Data Systems Processing Manager	1	0.15	0.5	1	1
IT/Data Analysts from IDN member organizations to support HIT vendor platform required activities	7	0	4	4	7
Front Office/Billing Support Staff	1.3	290.5	290.5	290.8	290.8
Administrative Assistant	<b>0.75</b>	27	27	27	<b>27.75</b>

### 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
Psychiatrist	1.95	.26	.26	.76	.93
Psychiatric APRN	1.3	0	0	0	0
Psychiatric Certified Nurse	1	0	0	0	0
Physician's Assistant (Certified)	0.2	0	0	.2	.2
Nurse Practitioner	.28	0	0	0	.28
Registered Nurse	1.7	0	0	0	.5
Consulting Pharmacist	.2	0	0	0	0
Medical Assistant	.28	0	0	.28	.28
Licensed Therapist	6.02	0	4.75	4.78	4.99
Master's Licensed Alcohol and Drug Counselor (MLADC)	14	0	0	0	2
Behavioral Health Clinician/Specialist	18.6	0	4	4	14
Behavioral Health Coordinator	4	0	0	0	0
Case Manager	9.5	0	0	3	5
Care Coordinator	17.25	5	6	9	10.75
Community Health Worker	8.71	0	1	3	3
Criminal Justice Specialist/Liaison	0.1	0	0	.1	.1
Supportive Employment Specialist	0.5	0	0	.5	0
Housing Specialist	0.1	0	0	.1	.1
Family Specialist	0.1	0	0	.1	.1
Peer Support Specialist	1.53	0	0	1	1
Administrative Office/Billing	2.37	.75	1.1	1.37	1.1
Clinical Operations	.2	0	.2	.2	.2
IT/Data Analyst, Manager, Operations	4.7	0	2.1	2.6	4.2

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
Program Evaluation Specialist	.5	0	0	0	.5
Director	1.35	1.35	1.2	1.2	1.2
Project Manager	2.5	0	1.5	1.5	2.5
Marketing/Education	.20	0	.20	.20	.20
Training Coordinator	0.5	0	.5	.5	.5

## 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 – December 2018): \$669,855.95

- CY 17 (July 2017 – December 2017): \$46,922.00
- CY 18 (January 2018 – December 2018): \$622,933.95
  - Jan – June 2018 actuals: \$303,787.00
  - July – December 2018 actuals: \$319,146.95

Projections are displayed for the July to December 2018 **due to remaining invoices to be processed for the reporting period, as well as projections for** CY 2019, CY 2020 and CY 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/fees to support advertising/**recruitment company fees; sign-on, referral and retention** bonuses, relocation expense reimbursement, student loan repayment, ~~staff~~ **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**



- and refugees (Ascentria Care Alliance)
- **Training Coordinator (.5 FTEs) to support Cultural Competency 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**
- **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**
- ~~Consultation for:~~
  - ~~Provider practice Site Self-Assessments (SSAs)~~
- 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. 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. **However** ~~Additionally,~~ services were provided during the reporting period for which the IDN has not fully processed invoices. Several invoices **still remain** ~~have been received~~, but have not yet been reflected in the budget table below, due to the holidays and other timing issues.

Therefore, expenditures reflected in the budget table below reflect the following:

- Workforce recruitment/hiring and retention/sustainability:
  - Greater Nashua Mental Health Center:
    - Staff referral bonuses for 4 staff
    - Recruitment agency fees (for hiring adult psychiatrist)
    - Recruitment ads/fees for multiple behavioral health positions
    - Staff recognition for 9 staff
    - Sign-on bonuses for 10 staff

- Retention bonuses for 3 staff
    - ~~MLADC~~ **Supervision stipends to support 6 LADCs moving toward MLADC**
    - **Supervision stipends to support 8 non-LADCs**
    - **Master’s level intern cohort stipends (2 FTEs, with one leaving the program in October)**
  - Lamprey Health:
    - Recruitment agency fees/dues **for 3 staff**
    - Stay incentives/retention bonuses **for 3 staff**
    - ~~Staff recognition~~
    - **Supervision stipend to support certification for a Physician Assistant**
  - **The Youth Council:**
    - **Master’s level intern cohort stipends (2 FTEs, with one leaving the program in October)**
    - **Supervision stipends to support 3 non-LADCs**
    - **Student loan repayment for 2 Behavioral Health Clinicians/Specialists**
- Workforce education and knowledge capacity building:
  - **License fees/professional dues**
    - **Greater Nashua Mental Health: 14 staff**
    - **Lamprey Health: 1 staff**
  - **Professional development/CEUs**
    - **Ascentria Care Alliance for 2 staff**
    - **Greater Nashua Mental Health for 22 staff**
    - **Lamprey Health for 3 staff**
    - **NAMI NH for 1 staff**
    - **The Youth Council for 2 staff**
  - ~~Workforce training~~ **Staff education and training:**
    - Ethics and Cultural Competency Skills training (7 sessions over June, July and August **provided by Ascentria Care Alliance**)
    - Advanced Motivational Interviewing training (July 30<sup>th</sup>) **provided by Peter Fifield**
    - Basic Motivational Interviewing training (October 4<sup>th</sup>) **provided by David Lynch and Christine Powers**
    - Chronic Disease Training for Behavioral Health Providers (October 31 and December 12) **provided by Tracy Tinker**
    - NH Behavioral Health Summit sponsoring 21 IDN 3 participants (December 10<sup>th</sup> – 11<sup>th</sup>) **provided by the NH Providers Association**
      - Conference workshop management hosting
      - Fees and management for CMEs, CNEs and CEUs, as well as professional recording for use in training after summit for up to 2 years
    - ~~Non-direct care staff training:~~
      - Youth Mental Health First Aid (November 15<sup>th</sup>) **provided by NAMI NH**
      - Greater Nashua Public Health Advisory Council Annual Meeting, aka IDN 3 BH Conference (October 10<sup>th</sup>)
  - Support for updating and printing of the NH Health Career catalogue **provided by Southern NH AHEC and North Country AHEC**
  - **Consultants**
    - Critical Time Intervention (CTI) training, technical assistance and Community of Practice facilitation **provided by Hunter College**

- Integrated Dual Diagnosis Treatment (IDDT) training, technical assistance and fidelity assessment/monitoring of action plan **provided by Case Western Reserve University**
- Enhanced/expanded staffing and services to support the IDN 3 integrated health care:
  - 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-CHW**) to support care coordination for new immigrants and refugees (**Ascentria Care Alliance**)
  - **Training Coordinator (.5 FTEs) to support Cultural Competency 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
  - **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)**
  - Clinical case management for clients with intellectual/developmental disabilities (monthly stipend) with **Gateways Community Services**

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

- ~~Workforce recruitment/hiring and retention/sustainability:~~
  - ~~Student loan repayment for Project IMPACT counselors with The Youth Council~~
  - ~~Staff education and training for GNMHC staff on communication~~
- ~~Workforce education and knowledge capacity building:~~
  - ~~Staff education and training (Ethical Communications) for the Peer and Family Peer Support Specialist with NAMI~~
- ~~Enhanced workforce capacity to support IDN strategies:~~
  - ~~Community Health Worker (1 FTE) with Ascentria Care Alliance~~
  - ~~Licensed Pastoral Psychotherapist (.5 FTE) with The Emmaus Institute~~
  - ~~Clinical case management for clients with intellectual/developmental disabilities (monthly stipend) with Gateways Community Services~~
  - ~~Americorps VISTA through Dartmouth Hitchcock Community Resource Corps (2 FTEs) with City of Nashua Department of Public Health and St. Joseph Hospital~~

For the remaining years of the DSRIP demonstration, projected funding allocations are broken down equally across 30 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	Jan-June 2018 Actuals	July-Dec 2018 Projected	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	\$2,594,281.58	\$0.00	\$24,266.00	\$201,461.00	\$414,563.80	\$168,943.71	\$879,844.35	\$879,844.35	\$439,922.17	\$2,594,281.58
Employee Benefits	\$14,699.56	\$0.00	\$0.00	\$0.00	\$0.00	\$14,699.56	\$0.00	\$0.00	\$0.00	\$14,699.56
Consultants	\$452,231.50	\$0.00	\$0.00	\$18,950.00	\$14,699.56	\$31,375.00	\$160,762.60	\$160,762.60	\$80,381.30	\$452,231.50
Equipment	\$6,519.56	\$0.00	\$3,385.00	\$0.00	\$0.00	\$3,134.56	\$0.00	\$0.00	\$0.00	\$6,519.56
Supplies (sum of lines below)	\$27,838.26	\$0.00	\$8,553.00	\$17,164.00	\$0.00	\$2,121.26	\$0.00	\$0.00	\$0.00	\$27,838.26
Educational		\$0.00	\$0.00	\$0.00						\$0.00
Medical/Lab/Pharmacy		\$0.00	\$0.00	\$0.00						\$0.00
Office	\$25,717.00	\$0.00	\$8,553.00	\$17,164.00		\$2,121.26				\$27,838.26
Travel (mileage/parking expenses)	\$7,943.65	\$0.00	\$270.00	\$3,996.00	\$0.00	\$3,677.65	\$0.00	\$0.00	\$0.00	\$7,943.65
Occupancy	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Current Expenses (sum of lines below)	\$5,880.77	\$0.00	\$838.00	\$1,637.00	\$0.00	\$3,405.77	\$0.00	\$0.00	\$0.00	\$5,880.77
Telephone		\$0.00	\$838.00	\$1,637.00		\$811.16				\$3,286.16
Internet costs		\$0.00	\$0.00	\$0.00						\$0.00
Postage		\$0.00	\$0.00	\$0.00						\$0.00
Printing and Copying		\$0.00	\$0.00	\$0.00		\$2,229.17				\$2,229.17
Audit and Legal		\$0.00	\$0.00	\$0.00						\$0.00
Insurance		\$0.00	\$0.00	\$0.00		\$365.44				\$365.44
Board Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Software	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Marketing/Communications	\$3,122.39	\$0.00	\$0.00	\$0.00	\$0.00	\$3,122.39	\$0.00	\$0.00	\$0.00	\$3,122.39
Staff Education and Training	\$78,054.55	\$0.00	\$9,610.00	\$42,100.00	\$0.00	\$26,344.55	\$0.00	\$0.00	\$0.00	\$78,054.55
Subcontracts/Agreements	\$13,244.20	\$0.00	\$0.00	\$7,500.00	\$0.00	\$5,744.20	\$0.00	\$0.00	\$0.00	\$13,244.20
Other (specific details mandatory):	\$37,095.46	\$0.00	\$0.00	\$0.00	\$0.00	\$37,095.46	\$0.00	\$0.00	\$0.00	\$37,095.46
Recruitment Fees		\$0.00	\$0.00	\$0.00		\$16,026.77				\$16,026.77
Sign-on Bonus		\$0.00	\$0.00	\$0.00						\$0.00
Staff Referral Bonuses		\$0.00	\$0.00	\$0.00						\$0.00
Relocation Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Student Loan Repayment/Reimbursement		\$0.00	\$0.00	\$0.00						\$0.00
Employee Recognition/Retention Bonus		\$0.00	\$0.00	\$0.00		\$2,571.09				\$2,571.09
CMEs/Professional Development		\$0.00	\$0.00	\$0.00						\$0.00
Professional Development Fees/Dues		\$0.00	\$0.00	\$0.00		\$18,497.60				\$18,497.60
Staff Licensing/Certification Supervision Stipend		\$0.00	\$0.00	\$0.00						\$0.00
Other: please specify below	\$30,461.84	\$0.00	\$0.00	\$10,979.00	\$0.00	\$19,482.84	\$0.00	\$0.00	\$0.00	\$30,461.84
<b>TOTAL</b>	<b>\$3,271,373.32</b>	<b>\$0.00</b>	<b>\$46,922.00</b>	<b>\$303,787.00</b>	<b>\$429,263.36</b>	<b>\$319,146.95</b>	<b>\$1,040,606.95</b>	<b>\$1,040,606.95</b>	<b>\$520,303.47</b>	<b>\$3,271,373.32</b>

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

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) 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): 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

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
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	A1, D3, E4
Harbor Homes	Federally Qualified Health Center	A1, A2, B1, D3
Healthy at Home	County Nursing and Jail Facility	A1, A2, B1
Hillsborough County Nursing Home and Corrections	Community-Based Organization	A2
Home Health and Hospice	Behavioral Health Provider	A2
Keystone Hall	Federally Qualified Health Center and Substance Use Treatment Provider	A1, A2, B1, D3
<b>LaMora Psychological Associates</b>	<b>Behavioral Health Provider</b>	<b>A2, B1</b>
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

<b>Organization Name</b>	<b>Organization Type</b>	<b>Associated with IDN Projects (A1, A2, B1, C, D, E)</b>
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): 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				

## ***A1 Behavioral Health Capacity Building Development: Attachments***

attachment\_A1.3a IDN Level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan

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)	
Complete	A. Actively participate in Statewide Workforce Task Force and individual WFTF Work Teams	
Complete	A1. IDN 3 is chair of the recruitment and hiring work team and convenes team regularly	
Complete	A2. IDN 3 is a member of the education and training work team participates in regular meetings	
Complete	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 support recruitment/hiring	Support HR staff for development of job descriptions and interviewing/onboarding new members of the workforce
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	Support 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

attachment\_A1.3a  
IDN-Level Workforce Capacity Development Implementation Plan

Status	Task Name	Comments
In progress	E4. Allocate funding to increase satisfaction of existing BH staff through loan repayment assistance	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	Support one-time salary increases, bonuses, formal recognition programs or other unique ways to recognize existing staff who work with IDN attributed Medicaid population
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	Support The Youth Council and GNMHC to conduct recruitment efforts for up to 6 Master's Level interns winter/spring 2018 to support youth/adolescents. Intern cohort begins fall 2018 and runs for 8 months with supervision provided by The Youth Council and GNMHC. Also includes funding to support CAQ certification for Lamprey Health primary care Physician Assistant and supervision for non-LADC clinicians to move to next level of licensure.
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
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	Includes support for Community of Practice (CoP) with other 4 IDNs implementing CTI strategy
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	Partner with the City of Nashua Department of Public Health as part of their Community Health Assessment (CHA) and Community Health Implementation Plan (CHIP)
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	
In progress	B. Recruit and hire IDN/DSRIP Quality Manager to support IDN goals and strategies	Hired a project manager to support training initially, but individual and left position in February 2018. Recruitment and hiring efforts will begin summer/fall 2018
Complete	C. Support implementation of a Student Assistance Program that provides screen, supportive counseling and referrals to higher levels of treatment 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 (SED)	
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, including expanded individual therapy services	
In progress	G. Support increased awareness of the diversity of cultures in the IDN through educational activities and trainings	
In progress	H. Support a CHW to provide care coordination and connections to primary care, behavioral health and social service support services to refugees and immigrants	
In progress	I. 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	J. Identify opportunities to support closed loop screening and referral services through outside contractors	Still determining potential use of outside contractor to support referrals

## ***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: Requirements, Timeline, Milestones and Evaluation 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 struggled to secure the necessary BAA/QSOA and Data Use Agreements (DUAs) as part of the A2: HIT IDN sub-contracting process throughout 2018 which has delayed 100% achievement of several of our HIT goals. The primary concerns which delayed the majority of our partners in execution of the sub-contracting throughout this reporting period have been:

- the uncertainty associated with data sharing, data security and patient confidentiality,
- complexity in sub-contracting structure
- the lack of resources and education at both partner and IDN 3 level
- delayed availability of IDN 3 protocols and guidelines around CCSA and MAeHC reporting
- and in some cases, lack of funding.

However, there was some significant progress made at the end of 2018 as the IDN has taken the following mitigation steps to address some of the above concerns:

- Invited Collective Medical and MAeHC to address vendor specific data sharing, patient confidentiality concerns at Full IDN 3 meeting in Q3 of 2018.
- Streamlined the entire sub-contracting model in Q3 of 2018
- Created partner liaisons for each of our partners as well as providing a HIT specific liaison to help guide, educate and answer any further questions and concerns in Q4 of 2018
- The HIT partner liaison worked closely with each partner for 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.
- With the use of the Smartsheet tool, partner liaisons have created detailed partner specific work plans to do project planning and to work closely with our partners on all aspects of their IDN projects.
- The Data/IT Committee meeting schedule was changed from quarterly to monthly to address or discuss issues/concerns/budgets more timely and effectively.
- The IDN put significant progress in formalizing the IDN 3 documents relevant to the CCSA and MAeHC reporting
  - IDN 3 CCSA Tool (Adult version – see attachment\_B1.8ai) approved by the Clinical Governance Committee on 06/14/18 (V1) and 08/09/18
  - IDN 3 CCSA Tool (Youth version - attachment\_B1.8aia) approved by the Clinical Governance Committee on 11/15/18
  - Some of our partners such as Lamprey, GNMHC and FMP have opted to incorporate the CCSA tool into their EHR system and have been defining the workflows for how the CCSA will be recorded within that organization's EHR.
  - IDN 3 Quality Measurement Protocols Policies (see attachment\_B1.8aiii) approved by the Clinical Governance Committee for the six month measures (Assess.01, Assess.02 and Assess.04) on 08/09/18 and for the annual measures (Assess.03, Care.03 and Hosp\_Inp.02) on 10/08/18

- Adult and Youth IDN 3 CCSA Overview and Pathways (see attachment\_B1.8av and attachment\_B1.8avi respectively) reviewed by Clinical Governance Committee in December 2018

The feedback from our partners was that HIT Introductions have been very helpful and welcomed. However, due to the fact that this process started later in Q4 of 2018, the completion of all the minimum requirements have spilled into early 2019. The below table reflects partners we engaged during the July to December 2018 reporting period and results from those one-on-one meetings. The partners who were already engaged with MAeHC and/or CMT, we engaged via their bi-weekly meetings.

<b>Partner Entity</b>	<b>Date of HIT Introduction Meeting</b>	<b>Progress &amp; Results Since...</b>
Ascentria	12/12/18	IDN Sub-Contracting Complete NIST Assessment in progress Kno2 Operational CMT install in progress MAeHC – N/A
City of Nashua – Dept. of Public Health	11/01/18	No progress
Crotched Mountain	10/24/18	IDN Sub-Contracting Complete NIST Assessment Complete Kno2 Operational CMT Operational MAeHC – N/A
The Emmaus Institute	11/07/18	IDN Sub-Contracting Complete CMT install in progress MAeHC Operational & Reporting
Foundation Medical Partners	Bi-Weekly Meetings	IDN Sub-Contracting Complete Kno2 Operational MAeHC Operational & Reporting
Gateways Community Services	10/03/18	No Progress
Granite State Independent Living (GSIL)	11/05/18	IDN Sub-Contracting in progress
Home Health and Hospice	11/13/18	IDN Sub-Contracting Complete NIST Assessment Complete Kno2 Operational CMT install in progress MAeHC – N/A
H.E.A.R.T.S.	11/14/18	No Progress
Lamprey Health	Bi-Weekly Meetings	IDN Sub-Contracting Complete NIST assessment as part of EHR DSM part of EHR CMT install in progress MAeHC Operational & Reporting
Life Coping	10/17/18	IDN Sub-Contracting Complete NIST Assessment in progress Kno2 Operational CMT install in progress MAeHC – N/A
NAMI NH	11/06/18	IDN Sub-Contracting Complete NIST Assessment in progress

		Kno2 Operational CMT install in progress MAeHC – N/A
SMHMC	Bi-Weekly Meetings	IDN Sub-Contracting Complete NIST assessment as part of EHR DSM part of EHR CMT Operational – ED transmitting MAeHC Operational & Reporting
St. Joseph Hospital and Physician Services	Bi-Weekly Meetings	IDN Sub-Contracting Complete MAeHC reporting in progress
YMCA	10/31/18	No Progress
The Youth Council	09/17/18	IDN Sub-Contracting Complete NIST assessment in progress CMT install in progress MAeHC Operational & Reporting

## Minimum HIT Capabilities/Standards

### Data Extraction and Validation

*Providers with EHR Systems:* Out of 8 partners who have Electronic Health Records (EHRs) who are expected to provide data extraction and validation for IDN attributed patients through the use of MAeHC:

Achieved: 6 are providing production data to MAeHC. The IDN is providing funding to support HIT and/or clinical reporting staff to build and deliver the files and participate in bi-weekly implementation calls with MAeHC and the IDN Admin Lead:

1. Dartmouth Hitchcock has been sending monthly data file extracts to MAeHC and will meet the February 15 2019 deadline as part of its one data file extract for their health system; sub-contracting with IDN 3 still pending;
2. FMP has been sending monthly extraction files to MAeHC and has also been conducting extension work with MAeHC to ensure data integrity and expect to meet the February 15 2019 deadline for the July-Dec. 2018 milestone;
3. Lamprey has been working with MAeHC with test data and will be submitting production data now that sub-contracting has been executed – expect them to meet the February 15 deadline for the July-Dec. 2018 milestone;
4. GNMHC has been sending monthly extraction files to MAeHC consistently and expect them to meet the February 15 deadline for the July-Dec. 2018 milestone;
5. SNHMC will be ready to begin its extracts for Hosp\_Inp.02 during Q1 of 2019 for their required measure reporting by 06/15/19;
6. St. Joseph Hospital has been working closely with MAeHC formulating their data extraction and will be submitting production data now that sub-contracting has been executed – expect them to meet the February 15 deadline for the July-Dec. 2018 milestones.

Not Achieved: The 2 who have not achieved this goal have not completed their sub-contracting process. We are expecting to re-engage with these partners in Q1 of 2019:

7. Partnership for Successful Living (Harbor Homes and Keystone Hall) has been experiencing a significant shift in its leadership, so has had to pause in its engagement in the IDN thus do not

expect them to meet this requirement; The IDN is expected to re-engage them early February 2019.

8. Merrimack River Medical Services has experienced delays in its engagement with sub-contracting and providing data, hoping to re-engage Q1 of 2019.

*Manual Data Entry Providers:* Out of 2 partners who will submit data through the MAeHC manual data portal:

Achieved: 2 are submitting data manually into MAeHC for July '18 to Dec. '18 reporting period and have met the deadline of 02/15/19.

1. The Emmaus Institute had both CCSA and Manual Data entry training from both the IDN and MAeHC on 11/28/18 and has entered data for July '18 to Dec. '18 reporting period.
2. The Youth Council also participated in both CCSA and Manual Data entry training from both the IDN and MAeHC on 11/29/18 for the IDN outcome measures and has entered data for July '18 to Dec. '18 reporting period.

## Secure Data Storage

Funding has been allocated for up to 31 (St. Joseph Hospital and STJ Physician Practices are rolled up into one budget) of the IDN Member provider entities to support the completion of a cybersecurity assessment to ensure compliance with NIST capabilities. This 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. Many of the partners have chosen to contract with our IDN-approved vendor (e.g., Sage) to achieve this capability/standard and submit documentation for reimbursement of the cost. However, for those organizations who have certified EHRs, they will have already had this assessment completed as part of that certification requirement, so they will provide the IDN with an attestation and invoicing documentation as part of their request for reimbursement of the costs associated with the assessment.

Achieved: Out of 34 organizations listed in table [A2-7. IDN HIT: Key Organizational and Provider Participants](#), 16 have met their Cybersecurity Assessment requirement or are currently in progress:

- 10 organizations have certified EHRs who complete an assessment as part of their certification requirement:
  1. Southern NH Medical Center
  2. Foundation Medical Partners
  3. Dartmouth Hitchcock
  4. St. Joseph Hospital
  5. St. Joseph Hospital and Physician Practices
  6. Greater Nashua Mental Health Center (GNMHC)
  7. Lamprey Health
  8. Merrimack River Medical Services
  9. New Hampshire Hospital
  10. Harbor Homes
  
- 2 organizations without EHRs have completed the NIST assessment in 2018 and are in the process of providing attestation and invoicing as part of their SFY19 budget allocations:
  11. Crotched Mountain
  12. Home Health and Hospice

- 4 organizations without EHRs have engaged Sage in Q4 of 2018 to complete their NIST assessment in Q1 of 2019:
  13. Ascentria: IDN completed e-introductions with Sage and Sage engaged with Ascentria on 12/12/18; Ascentria IT contact was pulled away for another project for a few weeks but is now re-engaged and getting approvals from legal and management for Sage's sub-contracting agreement (Professional Services Agreement – PSA) process and expect to have the assessment completed by end of February 2019.
  14. Life Coping: IDN completed e-introductions with Sage and Sage engaged with Life Coping on 10/30/18; Life Coping was to complete the sub-contracting process and was reaching out to their IT consultants to set up an initial technical conversation.
  15. Youth Council: IDN completed e-introductions with Sage and Sage engaged with The Youth Council on 12/12/18; The Youth Council has since completed the sub-contracting with Sage on 01/09/19 and is scheduled for the assessment the week of 2/4/19.
  16. NAMI NH: NAMI NH engaged with Sage on 09/07/18 and has since completed the sub-contracting process and is scheduled for the assessment the week of 2/4/19;

Not Achieved Goal: Out of 34 organizations listed in table [A2-7. IDN HIT: Key Organizational and Provider Participants](#), 18 have not initiated their Cybersecurity Assessment

- 1 partner has completed sub-contracting with the IDN and is expected to engage Sage in January 2019:
  1. The Emmaus Institute
- 2 partners are in the process of completing their sub-contracting with the IDN and are expected to engage Sage in Q1 of 2019:
  2. LaMora Psychological Associates
  3. Granite State Independent Living;
- 15 partners have not completed execution of their IDN sub-contracting and are not currently involved in this process:
  4. American Medical Response (AMR)
  5. Bridges Domestic and Sexual Violence Support
  6. City of Nashua Department of Public Health
  7. Courville Communities
  8. Front Door Agency
  9. Gateways Community Services
  10. H.E.A.R.T.S. Peer Support Center
  11. Healthy at Home
  12. Hillsborough County Nursing Home and Corrections
  13. Keystone Hall
  14. Revive Recovery Support Center
  15. Southern NH Services
  16. St. Joseph Community Services
  17. YMCA of Greater Nashua
  18. United Way of Greater Nashua

## Direct Secure Messaging (DSM) and Integrated Direct Secure Messaging

All IDN Member providers have been allocated funding to support annual contracting costs associated with contracting with the IDN-approved HIT vendor Kno2 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 Kno2 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 Committee to see if the committee wanted to consider another vendor or re-negotiate with Kno2. The decision was to re-negotiate and explore an IDN sponsorship agreement with Kno2 vs the current model where each provider sub-contracting with Kno2 directly and then completing an Attestation and Invoicing the IDN based on the budgeted amount for each provider. The process of re-negotiating, approval from both legal and the Finance Committee has carried over to January of 2019. This has impacted actual execution of Kno2 for those providers who hadn't already contracted with Kno2 before the NHHIO licensing expired.

For those IDN Member providers with certified EHRs, they have the ability to have integrated direct secure messaging within their EHR (a desired capability for the IDN), and therefore will submit documentation to support funding allocations to support securing this ability. All IDN Member providers who are expected to share PHI, including using this platform as part of their referral protocols and workflows, are expected to have achieved this interoperability. Some providers have already indicated they are meeting this standard.

**Achieved Goal:** Out of 34 organizations listed in table [A2-7. IDN HIT: Key Organizational and Provider Participants](#), 16 organizations 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 Kno2 or their own EHR integrated DSM:

- 9 organizations have certified EHRs who have the ability to send direct secure messages through their existing EHR as part of integrated direct secure messaging. Therefore, they will utilize funding allocations to support EHR integration of the CCDAs from the IDN to support this standard:
  1. Southern NH Medical Center
  2. Foundation Medical Partners
  3. Dartmouth Hitchcock
  4. St. Joseph Hospital
  5. St. Joseph Hospital and Physician Practices
  6. Lamprey Health
  7. Merrimack River Medical Services
  8. New Hampshire Hospital
  9. Harbor Homes
  
- 6 organizations have executed contracts with Kno2 during the reporting period and will submit DSM attestation forms along with their invoicing:
  10. Ascentria
  11. Crotched Mountain
  12. Greater Nashua Mental Health Center (GNMHC)
  13. Home Health and Hospice
  14. NAMI NH
  15. LaMora Psychological Associates
  16. Life Coping

**Not Achieved:** Out of 34 organizations listed in table [A2-7. IDN HIT: Key Organizational and Provider Participants](#), 18 organizations do not 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 Kno2 or their own EHR integrated DSM:

1. American Medical Response (AMR)
2. Bridges Domestic and Sexual Violence Support
3. City of Nashua Department of Public Health

4. Courville Communities
5. Front Door Agency
6. Gateways Community Services
7. Granite State Independent Living (GSIL)
8. H.E.A.R.T.S. Peer Support Center
9. Healthy at Home
10. Hillsborough County Nursing Home and Corrections
11. Keystone Hall
12. Revive Recovery Support Center
13. Southern NH Services
14. St. Joseph Community Services
15. The Emmaus Institute
16. The Youth Council
17. YMCA of Greater Nashua
18. United Way of Greater Nashua

### Shared Care Plan (SCP), Event Notification Service (ENS) Receipt

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, urgent/immediate care, and inpatient visits through directly contracting with Collective Medical Technologies (CMT) 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.

For those providers with EHRs, they will be eligible for one-time interface allocations for the set-up of in-bound (HL7 integration interface) and out-bound interfaces to support this capability. There has been progress during this reporting period for primary care and behavioral health providers related to the ability to access/contribute to the SCP and receive ADTs:

Achieved: Out of 31 organizations who are expected to receive ENS, 11 have the ability to receive ENS or are currently engaged in acquiring CMT for ENS and SCP:

The following 2 organizations have completed the CMT sub-contracting process and are able to receive ENS and have SCP capabilities:

1. Dartmouth Hitchcock executed its contract directly with CMT for its entire health system. The Admin Lead hosted an information session for IDN Member providers' legal and compliance staff in June to provide an overview of the data sharing and patient privacy protections in place with the MAeHC and CMT platforms.
2. Crotched Mountain has completed their sub-contracting with CMT, provided IDN 3 attributed patient profile data to CMT and are now able to monitor those patients via ENS.

The following partners have engaged CMT in Q4 of 2018 and expect to complete their process early Q1 of 2019

3. Ascentria: IDN completed e-introductions with CMT and CMT engaged with Ascentria on 12/12/18; Ascentria IT contact was pulled away for another project for a few weeks but is now re-engaged and completed the Discovery Form on 01/03/19 and are in the process of

completing the Master Service Agreement (MSA) and the registration process and expect to have ENS/SCP capability by end of February 2019.

4. GNMHC: IDN completed e-introductions with CMT and CMT engaged with GNMHC on 08/07/18; GNMHC completed its sub-contracting (MSA) process on 12/14/18 and has provided the patient profile file. They are in the process of setting their triggers to receive event notifications.
5. Life Coping: IDN completed e-introductions with CMT and CMT engaged with Life Coping on 09/27/18; Life Coping completed the Discovery Form on 10/17/18 and was to complete the sub-contracting process and reach back out to CMT for next steps.
6. The Youth Council: IDN completed e-introductions with CMT and CMT engaged with The Youth Council on 12/12/18; The Youth Council completed the Discovery Form on 12/13/18 and the Master Service Agreement (MSA) and the registration process on 01/02/19; they have also had the kickoff meeting with CMT on 01/10/19 and expect to have ENS/SCP capability by end of January 2019.

The following 3 partners have completed the necessary BAA/QSOA and Data Use Agreements (DUAs) with the IDN during this reporting period in 2018 and started their introductions with CMT in Q1 2019:

7. Lamprey Health – introduction completed on 01/08/19
8. The Emmaus Institute – introduction completed on 01/09/19
9. Home Health and Hospice – introduction completed on 01/16/19
10. NAMI NH – introduction completed on 01/23/19
11. FMP – introductory meeting scheduled for 01/30/18

Not Achieved: Out of 31 organizations who are expected to receive ENS, 20 have not engaged CMT during this reporting period for ENS and SCP:

The following 2 partners who are in the process of completing their sub-contracting with the IDN, are expected to be engaging with CMT in Q1 2019:

1. LaMora Psychological Associates
2. Granite State Independent Living (GSIL)

The following 17 partners have not started the engagement process with CMT:

3. American Medical Response (AMR)
4. Bridges Domestic and Sexual Violence Support
5. City of Nashua Department of Public Health
6. Courville Communities
7. Front Door Agency
8. Gateways Community Services
9. Harbor Homes
10. H.E.A.R.T.S. Peer Support Center
11. Healthy at Home
12. Hillsborough County Nursing Home and Corrections
13. Keystone Hall
14. Merrimack River Medical Services
15. Revive Recovery Support Center
16. Southern NH Services
17. St. Joseph Community Services
18. St. Joseph Hospital and Physician Practices
19. YMCA of Greater Nashua

## 20. United Way of Greater Nashua

### Shared Care Plan (SCP), Event Notification Service (ENS) Transmit

The two IDN3 hospitals (St. Joseph Hospital and Southern NH Medical Center) are expected to send and receive ADTs through the use of the PreManage ED platform along with SCP capabilities with Collective Medical Technologies (CMT).

Achieved: Out of 2 hospitals, 1 has the ability to transmit ADT's (Admission, Discharge, Transfer) for ENS:

1. SNHMC went live on 09/18/2018 with Pre-Manage ED, 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.

Not Achieved: Out of 2 hospitals, 1 has not engaged with CMT to have the ability to transmit ADT's (Admission, Discharge, Transfer) for ENS:

2. St. Joseph Hospital is expected to begin this process in Q1 of 2019 with the update to their migration to the Covenant Health EHR complete and the execution of their sub-contracting with IDN 3 formally completed on 01/09/19.

NOTE: New Hampshire Hospital - decision made to remove New Hampshire Hospital from this target due to the statewide review of their participation taking into consideration concerns with privacy of confidential data is still being addressed.

### Internet Connectivity

All IDN Member provider entities who store or capture Protected Health Information (PHI) for IDN attributed patients have a secure Internet connection. Based on our initial HIT assessment, we identified one provider partner who will be using allocation for a business grade Internet router for up to 5 provider partners, as well as monthly fees associated with secure Internet vendors and have requested it as part of their SFY '19 funding.

### Query/Response CCDA 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.
- Dartmouth Hitchcock uses EPIC as its EHR, so it has its own built-in query-based exchange system.

## Optional HIT Capabilities/Standards

### Discrete Electronic Data Capture/Collection

Identified as a desired capability/standard, the IDN has not identified a specific vendor to provide the ability for discrete electronic data capture/collection, which could be used as part of a closed loop e-referral solution. However, IDN 3 was notified that their DSM vendor, Kno2, is in the process of integrating Closed Loop Referral (CLR) functionality into their product. This product is already part of IDN 3 HIT solutions as the DSM vendor. It is our understanding that those with Kno2 will be provided the CLR functionality. *IDN 3 Closed Loop Referral Guidelines (see attachment\_B1.8aiv)* have been developed and reviewed by the Clinical Governance Committee on 12/18/2018, subsequently approved on 01/14/2019.

## Population Health Tools

Population health tools are not required by the IDN, as they are an optional capability/standard. However, the IDN Admin Lead is working with MAeHC and CMT to better understand the use of their platforms for tracking and monitoring patients who utilize the emergency departments and other inappropriate settings to meet their needs.

Since the go-live of CMT PreManage ED, 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 CMT PreManage (ambulatory) platform. During this reporting period the IDN has engaged CMT in providing region specific as well as statewide utilization reports. CMT is working with IDN 3 and their internal team to define requirements and use cases such as those available for their Oregon state initiative. As our providers start utilizing the CMT platform to monitor their patients, the IDN would be able to see how many and what type of triggers are in place, how many are actually triggered, how many providers are engaged, etc. This would not be at the patient level in order to adhere to patient confidentiality.

In addition, the IDN contracted a data analyst in Q4 of 2018 who analyzed claims-based (de-identified) data for the IDN attributed population from DHHS and the Medicaid MCOs and presented the analytics to our partners at both the 09/28/18 and 10/25/18 Full IDN meetings. Although the intent was not to provide data at an individual level, it did provide insight into the number of ED claims, percentage of Medicaid members per organization, top providers based on claims and organizations that "share" in the care of the IDN 3 attributed members.

The IDN has also acquired approval from the Data/IT Governance Committee on 11/27/18 to form the Data Governance Committee, a sub-committee of the Data/IT Governance Committee in 2019. The charter would include quality analysis of the outcome measures reporting to MAeHC, identify gaps and work with IND 3 partner clinical representatives as well as IT Report Writers to address any issues/concerns/gaps. In addition, this committee can also review DHHS provided claims data analytics provided by the IDN and Closed Loop Referral Tool (Kno2) analytics, when available.

## Capacity Management Tools

While capacity management tools are not required by the IDN, the IDN Admin Lead has continued to work with MAeHC and CMT to define the use of their platforms for tracking and monitoring patients who utilize Emergency Departments and other inappropriate settings to meet their needs prior to the IDN's operationalization of care coordination and case management guidelines/protocols. The IDN has the ability to access MAeHC 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 CMT's PreManage platform.

The data analyst contracted by the IDN met individually with Lamprey on 10/08/18 to provide insights into their specific population and discussed their current potential capacity and their current patient profile.

During this reporting period, the IDN has used the Smartsheet tool to develop partner specific work plans for project management and to gather progress on all IDN projects. Through this mechanism, the IDN is able to assess and discuss provider capacity, identify successes, barriers and concerns on all aspects of their projects. This collaborative approach has been critical in working closely with our partners to develop their workforce capacity.

### Secure Texting

Secure texting is not required, so the IDN has not had further discussions about this during the reporting period. The IDN IT/Data Governance Committee will research and make a determination about the feasibility of procuring secure texting capabilities for IDN provider organizations in Q2 of 2019.

### E-Consents

E-consents are not required, so the IDN has not had further discussions about this during the reporting period. The IDN IT/Data Governance Committee will research and make a determination about the feasibility of procuring these optional capabilities for IDN provider organizations in Q2 of 2019.

### Patient Engagement Technology

Patient engagement technology is not required, so the IDN has not had further discussions about this during the reporting period. The IDN IT/Data Governance Committee will likely conduct research and make a determination about the feasibility of securing patient engagement technology for IDN provider organizations by December 31, 2018.

## **Progress on HIT Evaluation Targets**

The following describes some challenges that the IDN has faced, especially related to the ability for specific IDN provider partners to report against the performance outcome measures to MAeHC.

### *Shifts in Leadership and Loss of Workforce*

The Partnership for Successful Living (including Harbor Homes, Keystone Hall and Healthy at Home) have lost several members of their leadership team and have had numerous shifts in staffing. They have expressed concerns about being able to take on IDN strategies during the reporting period, but are expecting to re-engage with the IDN Q1 of 2019.

### *Mergers/Consolidations and Migrations to New EHRs*

St. Joseph Hospital (SJH) and Physician Practices has been going through a system-wide electronic health record system implementation. Their pediatric practice is going from paper to electronic. The IT department was directed to focus solely on the implementation project most of 2018. They went live with their new system in May, and re-engaged in conversations to find a way for them to provide data to MAeHC and CMT in November of 2018. They allocated an IT resource to start the report writing necessary to submit the flat files to MAeHC

while the execution of the BAA/QSOA and DUA with the IDN was in progress. SJH completed their sub-contracting execution on 01/09/19 and expect them to meet the July to December 2018 reporting period deadline of 02/15/2019.

Merrimack River Medical Services also experienced a merger with Baymark and subsequently, had to migrate to the EHR being utilized by their partner. This has caused significant delays in MRMS’ engagement in the IDN,. Their re-engagement is expected Q1 of 2019.

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

Partners expressed concerns regarding patient privacy and data sharing for which both MAeHC and CMT completed several presentations to share further information with the intent to alleviate some of the concerns. Additionally, since the IDN is utilizing the DHHS contracting agreement and subsequent exhibits, several partners have expressed concern about the oversight and potential auditing expectations (clinically and financially) as a result. The IDN is hopeful that these have relieved some of the concerns in order to proceed.

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

Performance Measure Name	Target	Progress Toward Target	
		As of 06/30/18	07/01/18 – 12/31/18
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 MAeHC as the data aggregator and data warehouse by July 31, 2018.	<p>Progress Met: April 1<sup>st</sup> measures: DH provided data file extracts to MAeHC. FMP was able to provide test files to MAeHC, but did not execute the required BAA/QSOA and DUA with the IDN to allow for submitting production data.</p> <p>October 1<sup>st</sup> measures: It is expected that DH and GNMHC will submit data file extracts for the reporting period. Lamprey Health, FMP and GNMHC have been working closely with MAeHC to provide test files, but have not yet executed the required BAA/QSOA and DUA. Harbor Homes is not expected to complete its required data use agreements in time to begin work on the data files for this reporting period.</p>	<p>Not Achieved:</p> <p>6 out of 8 provider entities are providing production data to MAeHC for July ’18 to Dec ’18 reporting period and have met the MAeHC deadline of 02/15/19.</p>

Performance Measure Name	Target	Progress Toward Target	
		As of 06/30/18	07/01/18 – 12/31/18
Data Extraction and Validation	All of the IDN member provider entities will submit data through the MAeHC manual data portal to meet the reporting requirements for the IDN outcome measures by December 31, 2018.	In Progress: The Emmaus Institute and The Youth Council both participated in the January 2018 training provided by MAeHC to learn how to access and input data manually to report against the IDN outcome measures. For the April 1 <sup>st</sup> measures, none of the manual portal data providers were allowed to provide data, as MAeHC and DHHS were finalizing the protocols for those providers fall under 42 CFR Part 2. However, once those protocols have been finalized and IDN sub-contracts (including BAA/QSOAs and DUAs) have been executed, it is expected that the Emmaus Institute will provide data via the MAeHC manual portal.	Achieved: 2 out of 2 member provider entities have entered data manually into MAeHC for July '18 to Dec. '18 reporting period and have met the MAeHC deadline of 02/15/19.
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.	In Progress: While the IDN is aware of cybersecurity assessments having been completed by several of the member entities, including Southern NH Medical Center, Foundation Medical Partners, Dartmouth Hitchcock, St. Joseph Hospital and Physician Practices, and Lamprey Health, there are many who are in the process of securing this capability/standard through either the IDN recommended vendor/contractor or through one of their own choice.	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.
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 Kno2 or their own EHR integrated DSM. This interoperability standard will be in use no later than December 31, 2018.	Progress Met: GNMHC, Crotched Mountain, and Southern NH Health (both FMP and SNHMC) have executed contracts with Kno2 during the reporting period. Now that GNMHC and SNHMC have executed IDN sub-contracts, they will submit invoices and back-up documentation to the IDN for reimbursement now. Crotched Mountain purchased through their work with IDN 2.	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 Kno2 contracts in the reporting period.

Performance Measure Name	Target	Progress Toward Target	
		As of 06/30/18	07/01/18 – 12/31/18
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 Collective Medical Technologies (CMT) PreManage Primary SCP platform.	In Progress: The SCP and Case Management Work Team has been meeting to further identify the goals and use of the SCP as part of care coordination. GNMHC has executed the required BAA/QSOA and DUA with the IDN and will have contracted with CMT by August 30, 2018 to begin piloting the use of the approved statewide guidelines and categories of information included in the SCP. DH has executed its contract directly with CMT for its entire health system. The Admin Lead hosted an information session for member entity legal and compliance staff in June to provide an overview of the data sharing and patient privacy protections in place with the MAeHC and CMT platforms.	Not Achieved: 3 of 34 entities have completed the CMT sub-contracting process and have SCP capabilities.
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 CMT PreManage platform.	In Progress: Final testing is being completed with interfaces developed between SNHMC and CMT for Emergency Department event notifications. Now that GNMHC has executed its BAA/QSOA and DUA with the IDN, it will now contract directly with CMT by August 30, 2018, setting its own triggers and workflows for event notifications with its IDN attributed Medicaid population, based upon the IDN protocols and guidelines. DH has executed its contract directly with CMT for its entire health system.	Not Achieved: Out of 31 organizations who are expected to receive ENS, 2 have the ability to receive ENS.
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 PreManage ED platform with Collective Medical Technologies (CMT) by December 31, 2018. <b>Modified "3" hospitals to "2" removing NH Hospital.</b>	Progress Met: The interfaces and testing is now complete with SNHMC, through its work with CMT and its EHR vendor, LogicCare. St. Joseph Hospital is expected to begin this process in October 2018 with the update to their migration to the Covenant Health EHR. Discussions with NH Hospital continue.	Not Achieved: Out of 2 hospitals, 1 has the ability to transmit ENS.

Performance Measure Name	Target	Progress Toward Target	
		As of 06/30/18	07/01/18 – 12/31/18
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.	In Progress: No additional sub-contracts have been executed with the IDN to allow for funding of secure internet connections, which are expected for at least one of the IDN treatment providers. Sub-contracts are expected to be executed by early Fall.	Achieved: All IDN member entities have a secure Internet connection
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.	In Progress: Identified as a desired capability/standard, the IDN has not identified a vendor to provide the ability for discrete electronic data capture/collection, which could be used as part of a closed loop e-referral solution. In 2017, IDN met with vendors as part of a more regionalized effort with IDN 4 and 6, but has not determined it will move forward with the use of any of the vendors to date. There has been a budget allocation to support this ability in the 2017-2020 A2: HIT budget, but to date, no movement has been made to make a formal decision, however, it is expected the IT/Data Governance Committee will discuss and make a decision about this capability/standard by in Q1 of 2019.	Not Achieved: Awaiting Kno2 Closed Loop Referral functionality build for this solution
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.	Progress Met: DH has existing technology through its Epic EHR, as does FMP and SNHMC. Workflows and protocols, following the IDN protocols and guidelines, are currently in process, expected to be finalized by September 2018.	Achieved: 9 partners have existing integrated direct secure messaging technology through their certified EHR systems such as EPIC.

Performance Measure Name	Target	Progress Toward Target	
		As of 06/30/18	07/01/18 – 12/31/18
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 through the use of Eccovia or a similar vendor by June 30, 2019.	Progress Met: SNMHC 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 Summer 2018, following the IDN protocols and guidelines.	Achieved: Two IDN partners began the process of securing the ability to share, query, and retrieve data.
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.	In Progress: The IDN Admin Lead has been working with MAeHC and CMT to better understand the use of their platforms for tracking and monitoring patients who utilize the EDs and other inappropriate settings to meet their needs. The receipt of claims-based (de-identified) data for the IDN attributed population from DHHS and the Medicaid MCOs during this period will be further reviewed, as analysis support was provided by DHHS.	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 CMT PreManage (ambulatory) platform.
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.	In Progress: The IDN Admin Lead has been working with MAeHC and CMT to better understand the use of their platforms for tracking and monitoring patients who utilize the EDs and other inappropriate settings to meet their needs.	Achieved: The IDN has the ability to access MAeHC 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 CMT's PreManage platform.
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.	Progress Not Met: The IDN has not had further discussions about this during the reporting period.	Achieved: Due to lack of funding the determination has been made to not move forward with patient engagement technology

Performance Measure Name	Target	Progress Toward Target	
		As of 06/30/18	07/01/18 – 12/31/18
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.	Progress Not Met: The IDN has not had further discussions about this during the reporting period.	Achieved: Due to lack of funding the determination has been made to not move forward with securing texting capabilities

## A2-5. IDN HIT: Workforce Staffing

The IDN Data Systems Processing Manager started in June 2018 and has accounted for 1 FTE for this reporting period. We have not secured a Quality Improvement Manager to date, but have maintained the provider organization IT/Data Analyst staff who are supporting data reporting to MAeHC. These staff are part of Foundation Medical Partners (FMP), Southern NH Medical Center (SNHMC), Greater Nashua Mental Health Center (GNMHC), and Lamprey Health and St. Joseph Hospital.

- The GNMHC FTE has provided reporting as well as performed quality analysis on data being reported to MAeHC.
- Lamprey Health is using CHAN to provide the flat files required for MAeHC and 2 clinical staff members to review the data being sent to MAeHC.
- St. Joseph Hospital is using 1 FTE to provide flat files required for MAeHC and 2 application coordinators (subject matter experts) to review the data.
- FMP and SNMHC is using IT staff report writers to provide MAeHC flat files.
- Dartmouth Hitchcock is reporting from their central reporting so no specific FTE allocated for IDN 3.
- The 2 manual data entry organizations, The Emmaus Institute and The Youth Council, are using their allocated D3 project FTE's as part of their projects to validate and enter data into the MAeHC portal.

Staff Type	IDN Workforce (FTEs)			Staffing on 6/30/18
	Projected Additional Need for IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	
DSRIP Data Systems Processing Manager	1 FTE	0.15	0.5	1
DSRIP Quality Improvement Manager	0	0	0	0
DSRIP Integrated Health Project Manager	2 FTE	0	2	2
IDN Provider Organization IT/Data Analyst Staff with time allocated to support IDN data reporting/input needs	7 staff	0	4	7

Staff Type	IDN Workforce (FTEs)			Staffing on 6/30/18	Staffing on 12/31/18
	Projected Additional Need for IDN Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17		
IT/Data Analyst, Manager, Operations	4.7 FTEs	0	2.1	2.6	4.2
Director	.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): \$257,917.34

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$257,917.34
  - Jan – June 2018 actuals: \$303,787.00
  - July – December 2018 actuals: \$319,146.95

\*does not reflect all invoices expected from all IDN Member Entities for the July – December 2018 time frame.

Projections are displayed for the July to December 2018, as well as CY 2019, CY 2020 and CY 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
  - Event Notification Service (ENS) and Shared Care Plan (SCP) platform vendor (Collective Medical Technologies/CMT)
  - NIST Cybersecurity Resilience Assessment vendor

- Direct Secure Messaging (DSM) platform vendor (Kno2)
- Inter-vendor capabilities to share, query and retrieve data
- 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

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. 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.

Therefore, expenditures reflected in the budget table below reflect the following:

Employee salary/wages to support data extraction/reporting:

- Data extraction/validation for measures reporting and integration interfaces to support event notification alerts
  - Foundation Medical Partners (FMP)
  - Southern NH Medical Center (SNHMC)
- integration interfaces (in-bound and out-bound) to support event notification alerts (one-time allocations)
  - Foundation Medical Partners (FMP)
  - Southern NH Medical Center (SNHMC)
- EHR integration of CCDA to support integrated direct secure messaging (DSM) (one-time allocations)
  - Foundation Medical Partners (FMP)
  - Southern NH Medical Center (SNHMC)

Consultants:

- IDN data warehouse and Quality Reporting Service (QRS) vendor
  - Massachusetts e-Health Collaborative (MAeHC): interface and validation fees: **\$54,885**
    - Q2 2018: **\$37,635**
      - Foundation Medical Partners (kick-off)
      - DHMC – Nashua (production)
      - Lamprey Health Center/CHAN (kick-off)
      - Greater Nashua Mental Health Center (kick-off)
    - Q3 2018: **\$17,250**
      - Southern NH Medical Center (kick-off)
      - Foundation Medical Partners (production)
      - Greater Nashua Mental Health Center (production)
- Event Notification Service (ENS) and Shared Care Plan (SCP) platform vendor
  - Collective Medical Technologies/CMT: **\$32,618**

- PreManage EDIE Quarterly Subscription: Southern NH Medical Center: **\$15,289**
      - May – July 2018
      - August – October 2018
      - November 2018 – January 2019
    - PreManage Primary Quarterly Subscription: IDN Member Entity Sponsorship: **\$17,329**
      - May – July 2018
      - August – October 2018
      - November 2018 – January 2019
  - NIST Cybersecurity Resilience Assessment
    - Foundation Medical Partners (FMP): **\$10,000 reimbursement**
    - Southern NH Medical Center (SNHMC): **\$10,000 reimbursement**
  - Direct Secure Messaging (DSM) platform vendor (Kno2)
    - Southern NH Health: **\$300 reimbursement**

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

Employee salary/wages to support data extraction/reporting:

- Data extraction/validation for measures reporting and integration interfaces to support event notification alerts
  - Greater Nashua Mental Health Center (GNMHC)
- EHR integration of CCDA to support integrated direct secure messaging (DSM) (one-time allocations)
  - Greater Nashua Mental Health Center (sub-contracted to Valentine & Sons Seed Co.)

Consultants:

- IDN data warehouse and Quality Reporting Service (QRS) vendor
  - Massachusetts e-Health Collaborative (MAeHC):
    - 2019 annual subscription fees
    - Interface and validation fees for Q4 2018
      - LaMora Psychological Associates (kick-off)

## A2. 6a IDN HIT Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	Jan-June 2018 Actuals	July-Dec 2018 Projected	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	\$521,204.86	\$0.00	\$0.00	\$0.00	\$95,178.81	\$22,871.05	\$199,333.52	\$199,333.52	\$99,666.76	\$521,204.86
Employee Benefits	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Consultants	\$1,232,046.58	\$0.00	\$0.00	\$79,597.00	\$192,074.93	\$106,522.29	\$418,370.92	\$418,370.92	\$209,185.46	\$1,232,046.58
Equipment	\$120,000.00	\$0.00	\$0.00	\$0.00	\$20,000.00	\$0.00	\$48,000.00	\$48,000.00	\$24,000.00	\$120,000.00
Supplies (sum of lines below)	\$49,868.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$16,622.67	\$16,622.67	\$16,622.67	\$49,868.00
Educational		\$0.00	\$0.00	\$0.00		\$0.00				\$0.00
Medical/Lab/Pharmacy		\$0.00	\$0.00	\$0.00						\$0.00
Office		\$0.00	\$0.00	\$0.00						\$0.00
Travel (mileage/parking expenses)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Occupancy	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Current Expenses (sum of lines below)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Telephone		\$0.00	\$0.00	\$0.00						\$0.00
Internet costs		\$0.00	\$0.00	\$0.00						\$0.00
Postage		\$0.00	\$0.00	\$0.00						\$0.00
Printing and Copying		\$0.00	\$0.00	\$0.00						\$0.00
Audit and Legal		\$0.00	\$0.00	\$0.00						\$0.00
Insurance		\$0.00	\$0.00	\$0.00						\$0.00
Board Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Software	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Marketing/Communications	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Staff Education and Training	\$48,927.00	\$0.00	\$0.00	\$48,927.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$48,927.00
Subcontracts/Agreements	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other (specific details mandatory):	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Recruitment Fees		\$0.00	\$0.00	\$0.00						\$0.00
Sign-on Bonus		\$0.00	\$0.00	\$0.00						\$0.00
Staff Referral Bonuses		\$0.00	\$0.00	\$0.00						\$0.00
Relocation Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Student Loan Repayment/Reimbursement		\$0.00	\$0.00	\$0.00						\$0.00
Employee Recognition/Retention		\$0.00	\$0.00	\$0.00						\$0.00
CMEs/Professional Development		\$0.00	\$0.00	\$0.00						\$0.00
Professional Development Fees/Dues		\$0.00	\$0.00	\$0.00						\$0.00
Staff Licensing/Certification Supervision Stipend		\$0.00	\$0.00	\$0.00						\$0.00
Other: please specify below	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>TOTAL</b>	<b>\$1,972,046.44</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$128,524.00</b>	<b>\$307,253.74</b>	<b>\$129,393.34</b>	<b>\$682,327.11</b>	<b>\$682,327.11</b>	<b>\$349,474.89</b>	<b>\$1,972,046.44</b>

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

### Change in Partner Engagement

- The following partner was added in Q4 of 2018:
  - **LaMora Psychological Associates:** LaMora is actively engaged with MAeHC and working on their sub-contracting process. They have been very engaged in understanding all the HIT minimum requirements and associated vendors. They have met several times with MAeHC in understanding the reporting requirements and have already completed the MAeHC Manual Entry Training on 01/09/19 – expect they will be able to make progress in providing outcome measures before the 02/15/19 deadline for the reporting period of July – Dec. 2018 as well as having the opportunity to provide data for the previous reporting period of Jan. – June 2018 since they are a new partner.
- The following partners were unable to fully engage with the IDN during this reporting period:
  - Decision made to remove New Hampshire Hospital from this target due to the statewide review of their participation taking into consideration concerns with privacy of confidential data is still being addressed.

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) 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): 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

Organization Name	Organization Type
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 Center	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	County Nursing and Jail Facility
Hillsborough County Nursing Home and Corrections	Community-Based Organization
Home Health and Hospice	Behavioral Health Provider
Keystone Hall	Federally Qualified Health Center and Substance Use Treatment Provider
<b>LaMora Psychological Associates</b>	<b>Behavioral Health Provider</b>
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

Organization Name	Organization Type
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): 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

During this reporting period, several of our partners executed IDN sub-contracts that included the IDN's Data Use Agreement (DUA), developed in collaboration with MAeHC, to enable these providers to engage in data sharing for the purposes of measure reporting. As part of these sub-contracts, they also executed combination a BAA/QSOA to allow for guidance and accountability related to data sharing, data storage, and sub-contracting with other vendors.

The Partnership for Successful Living (the umbrella organization for Harbor Homes, Keystone Hall and Healthy at Home) is expected to execute their IDN sub-contracts and BAA/QSOA in Q1 of 2019, due to shifts in leadership/staffing capacity, mergers and migrations to new EHRs.

The IDN also expects that many of the other behavioral health and home/community-based social service support providers will execute their sub-contracts and data agreements by the end of the next reporting period to enable them to engage in the use of CMT for event notification and shared care plans (if applicable) and Kno2 for direct secure messaging. It is unclear at this time what the role of NH Hospital will be in supporting measure

reporting and their engagement in shared care plans and event notification service platforms, however, the organization is already working closely with GNMHC and its care transitions project (Critical Time Intervention), implementing workflows and protocols to support patients.

Below you will find the current status of all our partners and the execution of their Data Sharing Agreement (BAA/QSOA) with the IDN.

<b>Organization Name</b>	<b>Data Sharing Agreement Signed (Y/N) As of 06/30/2018</b>	<b>Data Sharing Agreement Signed (Y/N) As of 12/31/2018</b>
Dartmouth Hitchcock (DH)	In Progress: having legal conversations related to data sharing and terminology. Expected to resolve issues by October 31, 2018.	In Progress: having legal conversations related to data sharing and terminology. Expected to resolve issues by January 31, 2019.
Foundation Medical Partners (FMP)	In Progress: having patient privacy conversations related to data sharing. Expected to resolve issues by August 30, 2018.	Y
Greater Nashua Mental Health Center (GNMHC)	Y	Y
Harbor Homes	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues October 31, 2018.	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues Q1 2019.
Healthy at Home	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues October 31, 2018.	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues Q1 2019.
Keystone Hall	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues October 31, 2018.	In Progress: having legal conversations related to capacity and data sharing. Expected to resolve issues Q1 2019.
<b>LaMora Psychological Associates</b>		<b>N</b>
Lamprey Health	In Progress: having legal conversations related to data sharing and patient privacy, expected by October 31, 2018.	Y
Merrimack River Medical Services	N	N
St. Joseph Hospital and Physician Practices (SJH)	In Progress: having legal conversations related to capacity. Expected to resolve issues October 31, 2018.	Y
The Emmaus Institute	In Progress: having capacity-related conversations. Expected to resolve issues by October 31, 2018.	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				

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

attachment\_A2.3a: IDN HIT/HIE Implementation Plan: Requirements, Timeline, Milestones and Evaluation Plan

Status	Task Name	Comments
Completed	Phase One: Statewide HIT Taskforce: Facilitated Current State Assessment (July - September 2016)	
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)	
Completed	I. Support for achievement of overall DSRIP demonstration goals within the context of current HIT infrastructure gaps and HIT assessment	
Completed	II. Enable clinical outcomes and financial performance measurement and reporting functions within the IDN, across IDNs and between IDNs and the State	
Completed	III. IDN 3 analysis of member's current state related to Statewide HIT Minimum, Desired and Optional Capabilities and Standards	
Completed	III. Individual IDN Milestone: Develop Future State IDN-Specific Implementation Plans and Timelines (April - August 2017)	
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	MAeHC
Completed	A1. Complete contracting identification of project implementation timeline with MAeHC	
Completed	A2. Engage IDN members through role-based meetings to achieve buy-in of goals and objectives for data collection and data reporting for the IDN	
Not Applicable	A3. Implement ADT feeds for interfaces with MAeHC to ensure connectivity to data sources	Data/IT Committee made the decision to build extract files rather than send ADT feeds
In Progress	A4. Develop extracts from MAeHC for performance measures/metrics and data exchange	
In Progress	A4i. IDN member organization data analysts build data extract files (through funding/staffing allocations provided through the IDN) based upon technical specifications provided by MAeHC as provided by DHHS for 6 month measures Assess.01, Assess.02 A/B, Assess.04 for July to December 2108 reporting period before 02/15/2019 MAeHC deadline	
In Progress	A4ii. IDN member organization data analysts build data extract files (through funding/staffing allocations provided through the IDN) based upon technical specifications provided by MAeHC as provided by DHHS for 12 month measures Assess.03, Care.03, Hosp_Inp.02 for January to December 2108 reporting period before 06/15/2019 MAeHC deadline	
In Progress	A5. Secure Historical Data	
In Progress	A6. Implement use of the manual data entry portal	
Completed	B. Internet Connectivity (Minimum Capability/Standard): Support IDN members to have secure connections to the Internet to engage in goals of IDN	
In Progress	C. Data Storage (Minimum Capability/Standard): Support IDN members to increase their ability and knowledge through providing access to technology and training to secure PHI	
In Progress	C1. All IDN Member Entities will engage in a cyber security assessment to document level of secure data storage for PHI either within the first 12 months of the demonstration or within the last 12 months. IDN members will then seek reimbursement for costs (up to \$10,000 in first 12 months)	
Completed	C1i. Research NIST consultants who conduct cyber security assessments to recommend to IDN members who do not have their own	complete
In Progress	C1ii. IDN Member Entities complete NIST Assessment	Per the IT/Data Committee Chair, organizations are responsible for contract with a NIST security consultant to conduct the cyber security assessment either within the past 12 months or within the next 12 months. They will receive an allocation of up to \$10,000 for the first assessment. Year 2 funds are specifically for organizations without an EHR or to address critical non-compliance issues.
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 CMT and IDN for financial sponsorship and between CMT and IDN members for subscription/services	
In Progress	D2. Implement Transmit of Event Notification Service platforms for hospitals participating in pilot of PreManage ED	CMT PreManage ED
In Progress	D3. Implement Receiving of Event Notification Service platforms for ambulatory practices participating in pilot of PreManage	CMT PreManage (for ambulatory)
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).	
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	
Completed	F1. Conduct research on identified DSM vendor for IDN 3 (Kno2) to share contracting process with IDN member entities	complete
Completed	F2. Identify which IDN member entities require use of DSM	complete
In Progress	F3. IDN member organizations contract directly with Kno2	Start dates will vary for each organization
In Progress	G. 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	
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	Integrated Secure Messaging is not required by the IDN, therefore efforts to research options will be made at a later time.
Not Started	I. Discrete Electronic Data Capture (Desired Capability/Standard): Support applicable IDN members in their ability to capture discrete data and/or usage of a Certified Electronic Health Record Technology, as desired	Discrete electronic data capture is not required by the IDN, therefore efforts to research options will be made at a later time.
Completed	J. Closed Loop E-Referrals (Desired Capability/Standard): Support applicable IDN member providers in their ability to send referrals electronically in a closed loop system	IDN 3 was notified that their DSM vendor, Kno2, is in the process of integrating Closed Loop Referral functionality into their product. This product is already part of IDN 3 HIT solutions as the DSM vendor. It is our understanding that those with Kno2 will be provided the CLR functionality. IDN 3 Closed Loop Referral Guidelines have been developed and reviewed by the Clinical Governance Committee on 12/18/2018, subsequently approved on 01/14/2019.
Not Started	K. Secure Text (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	Secure texting is not required by the IDN, therefore efforts to research options will be made at a later time.
Completed	L. Population Health Tool (Desired 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	Since the go-live of CMT PreManage ED, 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 CMT PreManage (ambulatory) platform.  The IDN has also been working closely with our Data Analyst consultant who presented the analytics to our partners at both the 09/28/18 and 10/25/18 Full IDN meetings.  Out of this exercise, the IDN proposed creation of a sub-governance committee under the Data/IT Governance Committee called Data Committee which was approved by the Data/IT Governance Committee on 11/27/18. This committee's focus would be quality analysis to address gaps and identify what is working & what needs to be further addressed either via further reporting, clinical workflow re-evaluation or identified tools.
Not Started	M. Patient Engagement Technology (Desired 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.

Status	Task Name	Comments
Completed	N. Capacity Management Tools (Desired Capability/Standard): Support applicable IDN member providers in their ability to see utilization and availability	<p>The IDN Admin Lead has continued to work with MAeHC and CMT to define the use of their platforms for tracking and monitoring partner utilization through outcome measure data. In addition, with the use of the Smartsheet tool, partner liaisons have created detailed partner specific work plans to do project planning and to work closely with our partners on all aspects of their IDN projects.</p> <p>The IDN Data Analyst consultant met individually with Lamprey on 10/08/18 to provide insights into their specific population and discussed their current potential capacity and their current patient profile; this is a practice the IDN intends to continue in 2019.</p>

## ***Project B1: Integrated Healthcare***

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

#### **Progress, Barriers/Challenges and Mitigation Plans for Key Milestones and Activities**

*See attachment\_B1.2a: IDN Integrated Healthcare Implementation Plan Table*

Overall, there has been some progress in achieving the required deliverables associated with achievement of Coordinated Care Practice designation among the IDN 3 B1 partners, as well as some promising success among the strategies funded by the IDN across the various project funds. These strategies (funded through A1, A2, C, D and E projects) will enhance the region's approach to care coordination, community-based educational efforts to increase knowledge about behavioral health conditions and stigma, as well as expand capacity for existing treatment providers to address gaps in care across the region.

Additionally, the IDN Admin Lead's new approaches to interacting and sharing information with its Member Entity partners have supported increased transparency related to the key DSRIP deliverables, as well as the status for where they are individually and the IDN is as a whole in achievement of those deliverables. As outlined in the A1 section of this report, these efforts include:

- **initiating the IDN *Partner Liaison* model, which entails having a member of the Admin Lead team assigned to each IDN Member Entity. As part of this model, the Liaison:**
  - **built a work plan with concrete deliverables and associated milestones and timelines to support their assigned provider partner in movement toward achievement of deliverables by the end of the next reporting period (June 2019).**
    - **These work plans encompass the major deliverables for each partner, as well as the process and outcome targets set for their individual strategies in their annual IDN sub-contract Scope of Work.**
  - **meets monthly with each partner to identify issues/barriers to achievement and supports them as they implement mitigation plans to address the issues/barriers.**
- **developing and sharing dashboards with all of the Governance Committees at their monthly meetings, as well as with all IDN Member Entities at the Full IDN monthly meetings. These dashboards:**
  - **provide insights into the key deliverables for each statewide project (A1, A2, and B1) and filter up to an Executive Summary dashboard that provides an overview of how the IDN is progressing overall.**
  - **include accomplishments since the previous month, the risk/issues and IDN (and partner) mitigations to address them, and color-coded status for each key deliverable, ranging from:**
    - **gray (not started) to**
    - **red (major issues/critical path at risk) to**
    - **yellow (minor issues/critical path recovery feasible) to**
    - **green (on track).**

Following is an overview of the progress made as well as the barriers/challenges and mitigation plans the IDN and its partners have in place to work toward achievement of those milestones and deliverables targeted for the end of this reporting period, with goal of achievement by the end of the next reporting period (June 30, 2019).

#### Progress toward Coordinated Care Practice designation

##### *On-boarding and training Multi-Disciplinary Core Team (MDCT) members*

IDN 3 B1 partners have made progress in on-boarding and retaining providers needed to support achievement of Coordinated Care Practice/SAMHSA Plus deliverables. The use of funding allocations from the A1 project for some of the major partners has proven helpful to recruit and retain the needed workforce. As identified in attachment\_B1.8b (MDCT Members/Roles by Practice), there are 10 Multi-Disciplinary Core Teams (MDCTs) proposed for across the IDN primary care providers.

Below is the progress in filling those MDCT or B1-related roles, as of December 31, 2018:

- **Dartmouth Hitchcock:**
  - MDCT #1: complete, with their PCP, BH, Psychiatrist (.015 FTEs MD), and Care Coordinator (1 FTE) on-boarded.
    - Behavioral Health Clinician/Specialist (1 FTE; funded by the IDN) was on-boarded in Fall 2017 and has been retained through this reporting period.
    - Additional role of Community Health Worker (1 FTE; funded by the IDN) to support referral pathways for positive screens, is slated to be filled in early 2019.
  - MDCT #2: in progress, with the PCP, Psychiatrist (.015 FTEs MD) and Care Coordinator (2 FTEs) on-boarded.
    - Behavioral Health Clinician/Specialist (1 FTE) will be on-boarded in early 2019.
    - Additional role of Community Health Worker (1 FTE; funded by the IDN) to support referral pathways for positive screens, is awaiting approval for IDN supplemental funding for SFY '20.
- **Foundation Medical Partners:**
  - MDCT #1: in progress, with the PCP, BH (1 FTEs), and Care Coordinator (1 FTE) on-boarded.
    - Psychiatrist role (.03 FTEs MD) is in progress, with FMP having multiple psychiatric APRNs shared across their practices. With DHHS requirements outlining the need for this role being an MD (vs. an APRN), there are discussions occurring with leaders to determine capacity of existing staff to shift some time to focus on MDCT's monthly case management role.
  - MDCT #2: in progress, with the PCP, BH (1 FTEs Behavioral Health Clinician/Specialist) and Care Coordinator (1 FTE) on-boarded.
  - MDCT #3: in progress, with the PCP and Care Coordinator on-boarded.
- **Greater Nashua Mental Health:**
  - Critical Time Intervention (CTI) MDCT Participant: in progress, with the Team Coordinator (1 FTEs Licensed Therapist) and 2 of the 3 Specialists (2 FTEs Case Manager) on-boarded.

- One of the Specialists has been retained since November 2017, with the other retained since January 2018.
  - Integrated Dual Diagnosis Treatment (IDDT) MDCT Participant: in progress, with Psychiatrist (.5 FTEs), Nurse (.5 FTEs), Team Lead (1 FTE Licensed Therapist), Therapists (2 FTEs Licensed Therapists), Case Managers (2 FTEs), Criminal Justice Specialist/Liaison (.10 FTEs in-kind), Housing Specialist (.10 FTEs in-kind) and Family Specialist (.10 FTEs in-kind) on-boarded.
- Lamprey/InteGreat Health (Co-Located Practice designation with Greater Nashua Mental Health):
  - MDCT: in progress, with the PCP, Consulting Psychiatrist (.53 FTEs), Physician Assistant (.28 FTEs), SUD Clinician (1.03 FTEs Licensed Therapist), Medical Assistant (.28 FTEs), Clinical Care Coordinator (.25 FTEs), Case Manager (1 FTEs), Project Manager (.5 FTEs), Clinical Operations (.20 FTEs), IT Operations (.10 FTEs), Program Evaluation Specialist (.5 FTEs), and Billing and Health Information Support (.10 FTEs) on-board.
    - The Consulting Psychiatrist, Project Manager, Clinical Care Coordinator and Billing & Health Information Support have been retained since Fall 2017 with the Physician's Assistant, Medical Assistant, and Case Manager retained since Spring 2018.
- LaMora Psychological Associates:
  - MDCT Participant: completed, with multiple licensed behavioral health providers and lead team member, who is an MLADC and LICSW (.03 FTEs) Master Licensed Alcohol and Drug Counselor)
- Merrimack River Medical Services:
  - MDCT: in process through leveraging use of existing providers, including medical provider (MD), Social Worker (LICSW), and SUD Therapist (MLADC)
- Partnership for Successful Living (encompassing Harbor Homes and Keystone Hall):
  - MDCT: in process with PCP on-board.
- St. Joseph Hospital and Physician Practices:
  - MDCT #1: in process with PCP and Care Coordinator on board.
  - MDCT #2: in process with PCP and Care Coordinator on board.
- The Emmaus Institute:
  - MDCT Participant: completed, with existing Licensed Pastoral Psychotherapist (.5 FTEs) and Administrative Assistant (.25 FTEs)
- The Youth Council:
  - MDCT Participant: completed, with a Licensed Therapist (1 FTE) and Behavioral Health Specialists/Clinicians (2 FTEs)

Dartmouth Hitchcock Nashua's Internal Medicine Practice has been awaiting implementation of the CCSA. With respect to required training for B1 partners, there has been some progress but some distance to go to see achievement of all required training. However, there has been progress made during the reporting period, including:

As noted in the A1 section of this report, 24 trainings were offered during the July-Dec '18 reporting period as well as support and sponsorship of the Greater Nashua Public Health Advisory and the NH Behavioral Health Summit. There have been some challenges in engaging partner organizations in the training opportunities IDN 3 has offered, particularly for those identified as being multi-disciplinary core team members. Of those 24 trainings, there were over 325 attendees (non-unique participants) with a total of 85 multi-disciplinary core team members (non-unique participants) during this reporting period. Ultimately the targets, by training content, have not generally been reached over the course of the entire demonstration. The MDCT training participation levels appeared to vary depending upon the training logistics (content, length of time, location, etc.).

Universal Screening/CCSA training:

- The overall target of up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers by 12/31/18 was not achieved. There were a total of 39 participants in universal screening/CCSA trainings across all reporting periods with 25 members of an MDCT.
- This reporting period, there was participation by 19 attendees across 3 training opportunities. Of the 25, 5 were MDCT members.

Co-occurring Disorders training:

- The overall target of up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers by 12/31/18 was not achieved. There were a total of 31 participants in co-occurring disorders trainings across all reporting periods with 16 members of an MDCT.
- This reporting period, there were 2 trainings resulted in 20 participants, of which only 2 were MDCT members.

Care Planning/Care Coordination training:

- The overall target of up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers by 12/31/18 was achieved. There were a total of 63 participants in care planning/care coordination trainings across all reporting periods with 88 members of an MDCT.
- This reporting period, there were a number of trainings both sponsored by the IDN as well as included in the Behavioral Health Summit resulting in 42 MDCT member participants.

Cultural Competency and Adaptation training:

- The overall target of up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers by 12/31/18 was not achieved. There were a total of 243 participants in cultural competency training across all reporting periods with 43 members of an MDCT.
- This reporting period, there were a number of trainings offered for various cultural competency topics resulting in 218 participants, of which 8 were MDCT members.

Understanding Addiction training:

- The overall target of up to 30 physical health providers, 20 behavioral health providers, and 10 care coordinators/case managers/Community Health Workers by 12/31/18 was not achieved. There were a total of 23 participants in understanding addiction training across all reporting periods with all 23 members of an MDCT.
- This reporting period, the trainings had 5 MDCT members in attendance.

**B1 workforce capacity has several identified barriers/challenges preventing achievement of on-boarding all providers needed to achieve Coordinated Care Practice designation.**

- **Dartmouth Hitchcock:**
  - **Issue: sub-contracting with the IDN was not completed as of the end of the reporting period due to legal contracting language, concerns about data sharing and uncertainties with county matching funds.**
    - **Mitigation: this process has been underway, with much of the issues/concerns addressed between the DH and IDN legal counsel. Execution of the sub-contract is expected in early 2019.**
  - **Issue: supplemental funding is needed to support staffing capacity (additional 1 FTE Community Health Worker) for DH to ensure accomplishment of deliverables. This funding that was not originally proposed and/or approved with project plans in 2017.**
    - **Mitigation: a proposal was drafted by DH and submitted in the Fall 2018, with the IDN Clinical, Finance and Steering Committees expected to make decisions about approval of supplemental funds when confirmation of amount of county matching funds is received.**
  
- **Foundation Medical Partners:**
  - **Issue: Psychiatrist role (.06 FTEs MD) across all 3 MDCTs is currently filled by psychiatric APRN. Per DHHS, this role must be an MD (not an APRN).**
    - **Mitigation: discussions continue with the provider to identify potential use of existing psychiatric staff to support the MDCTs monthly case management needs.**
  - **Issue: FMP decided not to accept any of the IDN A1 or B1 funding allocations throughout the demonstration. This funding would have supported the following provider roles: Psychiatric APRN (.8 FTEs), Behavioral Health Specialist (2 FTEs), Behavioral Health Coordinator (1 FTE) and Receptionist (1 FTE Administrative Office/Billing/PSR).**
    - **Mitigation: will continue to work with FMP leadership to ensure their continued engagement in the region's efforts toward integrated care. They did accept A2 project funds to support DSRIP Outcome Measures reporting and engage with the information sharing platforms, which will build upon their existing organizational priorities.**
  
- **Greater Nashua Mental Health:**
  - **Issue: Team Coordinator (1 FTE Licensed Therapist) on-boarded in October 2017 left the position in early 2018, with the Clinical Supervisor (.15 FTEs) having to take on that role while a replacement was on-boarded. The 3<sup>rd</sup> Specialist (.5 FTEs) was not advertised to date to allow for time to observe the lessons learned and needs to support the program moving forward.**
    - **Mitigation: work with the CTI team to identify staffing needs moving forward given lessons learned and staff on-boarding process to determine next steps.**
    - **Critical Time Intervention (CTI) MDCT Team Participant: in progress, with the Team Coordinator (1 FTEs Licensed Therapist) and 2 Specialists (2 FTEs Case Manager) on-boarded.**
    - **One of the Specialists has been retained since November 2017, with the other retained since January 2018.**

- **Integrated Dual Diagnosis Treatment (IDDT) MDCT Team Participant:**
  - **Issues:** several of the key team roles have either left their position or not been on-boarded yet, including the Supported Employment Specialist (.5 FTEs), Peer Support Specialist (.5 FTEs) and Psychiatrist (.5 FTEs).
    - **Mitigation:** GNMH will utilize A1 funds to support workforce incentives for advertising and on-boarding these roles. Additionally, they will complete sub-contracting with HEARTS Peer Support Center to fill the Peer Support Specialist by early 2019.
- **Lamprey Health (InteGreat Health Co-Located Practice designation with Greater Nashua Mental Health):**
  - **Issues:** Several providers have left the project during the reporting period, including the Nurse Practitioner (.28 FTEs) and Patient Service Representative (.27 FTEs). Other providers are still in the process of being on-boarded due to lack of qualified/experienced applicants, including the Consulting Pharmacist (.20 FTEs) and Community Health Worker (.71 FTEs).
    - **Mitigation:** Lamprey will utilize IDN A1 project funds to support recruitment/hiring incentives as well as for sponsored ads and professional job boards to solicit qualified applicants. Lamprey plans to engage the on-site Genoa Pharmacy in exploring filling this role in early 2019.
- **Merrimack River Medical Services:**
  - **Issues:** organization merged with BayMark in late 2017/early 2018 and subsequently has on-boarded a new EHR system, causing sub-contracting with the IDN to be on hold as the new corporate leadership needed to better understand the IDN and DSRIP deliverables.
    - **Mitigation:** continue working with the organization and its new leadership to assess their capacity to engage in the IDN and accept allocated funds, which would support a Psychiatric APRN (.5 FTEs) and Behavioral Health Coordinator (1 FTE).
- **Partnership for Successful Living (encompassing Harbor Homes and Keystone Hall):**
  - **Issues:** sub-contracting with the IDN was not completed as of the end of the reporting period due to legal contracting language, concerns about data sharing and uncertainties with county matching funds.
    - **Mitigation:** this process has been underway, with much of the issues/concerns addressed between the DH and IDN legal counsel. Execution of the sub-contract is expected in early 2019 with funding to support Psychiatric APRN (.5 FTEs), Psychiatric Certified Nurse (1 FTE), Integrated Care Case Manager (4 FTEs Case Manager), and Community Health Worker (1 FTE).
- **St. Joseph Hospital and Physician Practices:**
  - **Issues:** organization merged with Covenant Health in late 2017/early 2018 and subsequently has on-boarded a new EHR system, causing sub-contracting with the IDN to be on hold as the new corporate leadership needed to better understand the IDN and DSRIP deliverables.
    - **Mitigation:** continue working with the organization and its new leadership to assess their capacity to engage in the IDN and accept allocated funds, which

would support an Embedded Behavioral Consultant-Pediatric (.6 FTEs), Embedded Behavioral Health Consultant-Adult (1 FTE), Child Psychiatrist/Psychiatric APRN (.4 FTEs) and Psychiatrist/Psychiatric APRN (.2 FTEs).

With respect to achieving the training deliverables for both MDCT members, as well as non-direct care providers, there were several issues that have been identified. The IDN mitigation plans associated with those issues are outlined below.

- **Issue: Multi-disciplinary core team clarity has been a challenge, especially with respect to identifying who the specific individuals are within each practice/organization, causing challenges in ensuring participation in trainings, monthly case management meetings, etc.**
  - **Mitigation: IDN 3 partner liaisons have made progress, and will continue to finalize, the identification of these team members**
  
- **Issue: Ensuring robust training offering by category to engage providers in wanting to attend/participate.**
  - **Mitigation: A monthly review of future trainings offerings is scheduled to ensure that all training categories have sufficient opportunities, in various formats/timeframes/locations for MDCT members to attend.**
  
- **Issue: Lack of training formats to engage providers in wanting to attend/participate.**
  - **Mitigation: In January, the IDN will take advantage of the NHHF and other web-based trainings to provide shorter training opportunities while simultaneously eliminating travel time to in-person trainings. Additionally there will be more emphasis on providing trainings at the practice locations to assist in ease of participation in training opportunities.**
  
- **Issue: Publicizing trainings in a way that draws attention to the providers who need to take advantage of them.**
  - **Mitigation: In January, the IDN will begin a multi-page bi-weekly publication of training opportunities in order to maximize visibility to all IDN partners and encourage timely consideration of participation, shown in the graphic below:**



## IDN3 Upcoming Training Opportunities 1/9/19

Category	Training	Description/Learning Objectives	Date/ Time	Audience	Format	CEUs	For More Information and to Register
<b>Understanding Addiction</b>							
	<i>SBIRT for Providers</i>	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 10am - 12pm	providers	webinar	2	<a href="https://attendee.gototrain.com/r/6613903685438084353">https://attendee.gototrain.com/r/6613903685438084353</a>
			2/14/19 10am - 12pm	providers	webinar	2	<a href="https://attendee.gototrain.com/r/4921610154757231105">https://attendee.gototrain.com/r/4921610154757231105</a>
	<i>Substance Related and Addictive Disorders Module 7 - Opioid Related Disorders</i>	Attendees 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 10 - 11:30am	providers	webinar	1.5	<a href="https://attendee.gototrain.com/r/3106121843739826433">https://attendee.gototrain.com/r/3106121843739826433</a>
	<i>Substance Related &amp; Addictive D/O; Module 1 - DSM-5 Criteria &amp; Diagnostic Information Overview</i>	Attendees 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 10am - 12pm	providers	webinar	2	<a href="https://attendee.gototrain.com/r/7615121172732642562">https://attendee.gototrain.com/r/7615121172732642562</a>
<b>Care Planning/Care Coordination</b>							
	<i>Basic Motivational Interviewing</i>	<ul style="list-style-type: none"> <li>Learn and understand the spirit and principles of Motivational Interviewing</li> <li>Demonstrate and use some basic motivational interviewing skills and tools</li> <li>Practical application of the basic micro skills and COD treatment</li> </ul>	1/25/19 8:30am-12:30pm	all	in person; 22 Cotton Rd Nashua	4	<a href="https://greaternashuaidn.org/evrplus_registration/?action=evrplusregister&amp;event_id=22">https://greaternashuaidn.org/evrplus_registration/?action=evrplusregister&amp;event_id=22</a>

### CCSA Implementation

There has been some progress among the B1 partners to achieve implementation of the required annual CCSA process with their attributed Medicaid population.

#### Progress:

During this reporting period, the IDN CCSA and Referrals Work Team finalized the *IDN 3 Adult and Youth CCSA Tool* (see attachment *B1.8ai* and attachment *B1.8aii*), *Outcome Measures Protocols and Guidelines* (see attachment *B1.8aiii*), *Adult and Youth CCSA Referral Pathways* (see attachment *B1.8av* and attachment *B1.8avi*) and the *Closed Loop Referral Guidelines* (see attachment *B1.8aiv*) to be used by primary care, mental health and substance use disorder provider. Once the approved versions of these documents were made available, the IDN educated partners on the twelve domains of the CCSA, focusing on the Social Determinants of Health areas and potential pathways for those issues and outcome measure reporting requirements both at Full IDN meetings and during one on one partner trainings. This included discussions of Care Coordination and Closed Loop Referral guidelines.

Part of this process of developing these guidelines included reaching out to all of the IDN providers with a questionnaire requesting they provide us with their current referral pathways for each of the 12 domains. Four partners responded to this questionnaire regarding their current state process for referrals which helped inform the IDN developed guidelines. In addition, The Youth Council's involvement in the Youth CCSA Tool was significant in its creation and use at The Youth Council.

The responses from the questionnaire were supporting information used in the *IDN 3 Quality Measurement Protocols Guidelines* (see attachment *B1.8aiii*) and both the Youth and Adult IDN 3 CCSA

~~Overview and Pathways Guidelines (see attachment\_B1.8av and attachment\_B1.8avi) documents, approved by the Clinical Committee during the reporting period. These responses also served as the basis of the IDN protocols/guidelines for the completion of the CCSA (ASSESS\_SCREEN.01), as well as positive depression and SUD screens and follow-up (ASSESS\_SCREEN.02) and tobacco cessation and counseling (ASSESS\_SCREEN.04).~~

In lieu of using the IDN 3 CCSA tool, some of our IDN partners shared their proposed CCSA tools/processes to the IDN Admin Lead/Clinical Governance Committee for review and approval, which is a requirement for all IDN Member Entity providers who are not using the IDN 3 CCSA tool (or the Dartmouth Hitchcock CCSA tool), per the IDN protocols/guidelines.

- Dartmouth Hitchcock met with the IDN team and others from the DH system in June to review the CCSA required domains and crosswalk those with the questionnaire content available in EHR that aligns with those domains.
- GNMHC proposed a compilation of existing screening and assessment tools already in use with their ANSA (Adult Needs and Strengths Assessment). The compiled tool and process were approved for use during the January – June 2018 reporting period, and was subsequently reported to MAeHC as part of GNMHC’s data file extracts.
- Foundation Medical Partners confirmed their use of the IDN 3 CCSA Tool with their target sub-population: the Complex Care Management population. A total of 4 CCSAs were completed by Embedded Care Coordinators during the reporting period.
- Lamprey submitted their CCSA Tool for approval in September and received approval in October of this reporting period.
- Emmaus Institute providing low acuity SUD consultation and counseling services has completed 4 CCSAs out of the 6 patients seen during the reporting period.
- The Youth Council providing BH services in two middle schools have completed 6 CRAFFT assessments and 2 CCSAs.

Even though there was significant progress in this area, several of the IDN provider practices were not able to implement the CCSA process. This included LaMora Psychological Associates, Partnership for Successful Living (including Harbor Homes and Keystone Hall) and St. Joseph Hospital and Physician Practices. The following are some of the challenges:

- Issue: Electronic Development of the CCSA Tool:
  - Challenge: As mentioned previously, IDN primary care and behavioral health care providers have the ability to implement the IDN 3 CCSA tool, the Dartmouth Hitchcock CCSA tool or another CCSA tool/process that crosswalks to the required 12 domains and uses the results as part of an individualized care plan. The use of an alternative tool/process is required to be approved by the IDN Clinical Governance Committee through a crosswalk and justification of its use for approval. While this allows for flexibility in the use of the CCSA processes that work most efficiently/effectively for each provider partner, it does require the process of “approval” to occur fairly quickly and may prove challenging for those providers who may be working to pull the CCSA domain-related information from various existing tools with internal workflows to incorporate into a patient care/treatment plan. The platform for implementing the CCSA (paper vs. built into an organization’s EHR) has certainly added another element of complexity in the decision-making for the IDN provider partners.

- Mitigation: While an electronic tool is being developed, the partner is able to use their current version of an assessment tool to provide required outcome measures with approvals such as GNMHC who has been able to their ANSA.
- Issue: Guideline Document and Partner Liaison Availability Delays:
  - Challenge: Approvals and availability for supporting documents such as the *IDN 3 Quality Measurement Protocols Guidelines* (see *attachment\_B1.8aiii*) and both the Youth and Adult *IDN 3 CCSA Overview and Pathways Guidelines* (*attachment\_B1.8av* and *attachment\_B1.8avi*) documents as well as the establishment of the partner liaisons came in the later part the measurement period, delaying providing guidance and working with our partners to develop their workflows based on these guidelines.
    - Mitigation: In Q4 of 2018, the IDN and the Clinical Governance Committee’s focus was to complete, review and approve these documents and the IDN was able to actively work with and supported our partners implementing the CCSA process and provide Outcome Measure Statics to MAeHC. In addition, the IDN put a lot of effort in the creation of partner liaisons (and HIT liaison) for each partner for customized education, setting up structure around getting and providing status updates, address feedbacks/questions/concerns around their workflow development for the projects defined in their SOWs.
- Issue: Partner Resource and Funding Availability and Concerns regarding Workflow Change Impact:
  - Challenge: Another challenge has been acquiring or identifying the resources and funding necessary to support the end to end CCSA process. Whether it was already existing staffing gaps, adding new workflows to already tight workflows, or resource turnover, this effected execution of project milestones on the clinical side, as well as reporting requirements.
    - Mitigation: Partner liaisons and IDN Admin Lead worked and continue to work closely with partners to identify gaps and budget planning during the SFY 19 contracting process.
- Issue: Uncertainty associated with data sharing, data security and patient confidentiality:
  - Challenge: Partners were concerned about preserving patient information security and confidentiality with new tools and processes being introduced which delayed either the execution of their sub-contracting or implementation and reporting of the CCSA process.
    - Mitigation: Again, the partner and HIT liaison and the Admin Lead worked closely with each partner to address their concerns. In addition, the IDN Invited Collective Medical and MAeHC to address vendor specific data sharing, patient confidentiality concerns at Full IDN 3 meeting in Q3 of 2018.

### Use of Information Sharing Technology

To support the identification and management of at-risk patients, use of the CMT event notification platform in the ED and setting are important tools. Admissions, discharges, and transfers (ADTs) will be in-bound to the emergency rooms for IDN attributed Medicaid patients who have met the identified criteria for triggers. These triggers when met will display a flag within the EHR system, allowing the treating ED provider to click on it and view security events, visit summary and, when input by the patient’s

case manager/treatment provider(s), will display names and contact information for each member of the patient's care team as well as care recommendations/guidelines, following the IDN protocols/guidelines.

SNHMC has completed the contracting and platform interfacing process with PreManage ED through CMT and went "live" on 09/18/18 transmitting event notifications. St. Joseph Hospital is expected to complete this process early Q1 of 2019 (once they have rebuilt their staffing capacity after the change in leadership, merger with Covenant Health and migrated to a new EHR). The IDN continues conversations with NH Hospital to determine the feasibility of implementing PreManage ED with their EHR and existing workflows, with the goal of moving forward this fall, if possible.

As IDN Member entity provider partners executed their BAA/QSOAs (and where applicable, their DUAs) as part of the sub-contracting process during this reporting period, 2 partners (Dartmouth Hitchcock and Crooked Mountain) have executed contracts and BAA/QSOAs directly with CMT for the PreManage platform and are able to participate in receiving event notifications and SCP for their attributed population. 4 partners (Ascentria, GNMHC, Life Coping and The Youth Council) began the contracting process in Q4 of 2018 and expect to complete the CMT process Q1 of 2019.

Even though there was significant progress in meeting the deliverable of partners having access to ENS/SCP, the following are some of the challenges faced in procuring CMT:

- Uncertainty associated with data sharing, data security and patient confidentiality:
  - Challenge: Partners were concerned about preserving patient information security and confidentiality with new tools and processes being introduced which delayed either the execution of their sub-contracting or implementation and reporting of the CCSA process.
    - Mitigation: In Q4 of 2018, the IDN created partner and HIT specific liaisons for each of our partners. The HIT liaison began 1-1 meetings with each partner to provide HIT Introduction education to address their concerns. The feedback from our partners was that HIT Introductions have been very helpful and welcomed. In addition, the IDN Invited Collective Medical to address vendor specific data sharing, patient confidentiality concerns at Full IDN 3 meeting in Q3 of 2018. These actions helped in execution of IDN sub-contracting as well as beginning the sub-contracting process with these vendors. Although not many of our partners have completed the entire process by the end of the reporting period, significant progress has been made in partner engagement.

There has been significant progress with compiling existing workflows or protocols with our IDN member entity partners, as well as developing workflows and protocols associated with IDN funded strategies.

During this reporting period, the IDN has completed the Governance Committee (Clinical Governance Committee – CGC) approval process and shared the following approved documents with our partners outlining IDN 3 protocols, guidelines and best practices. These documents have been discussed/presented at several Full IDN meetings and are being used as reference as our partners review and revise/add to their current workflows:

Interactions between providers and community based organizations:

1. IDN 3 Closed Loop Referral Guidelines – Approved (see attachment\_B1.8aiv)
2. IDN 3 Multi-Disciplinary Case Management Guidelines – In Process
3. IDN 3 Adult CCSA Overview and Pathways Guidelines - Approved (see attachment\_B1.8av)

4. IDN 3 Youth CCSA Overview and Pathways Guidelines – Approved (see attachment\_B1.8avi)
5. IDN 3 Quality Measurement Protocols Guidelines- Approved (see attachment\_B1.8aiii)

Timely communication:

1. IDN 3 Closed Loop Referral Guidelines - Approved (see attachment\_B1.8aiv)
2. IDN 3 Multi-Disciplinary Case Management Guidelines – In Process
3. HOSP\_INP.02 - this measure is described in IDN 3 Quality Measurement Protocols Guidelines - Approved (see attachment\_B1.8aiii)

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

1. IDN 3 Closed Loop Referral Guidelines - Approved (see attachment\_B1.8aiv)
2. IDN 3 Multi-Disciplinary Case Management Guidelines – In Process

Coordination among case managers (internal and external to IDN):

1. IDN 3 Closed Loop Referral Guidelines - Approved (see attachment\_B1.8aiv)
2. IDN 3 Multi-Disciplinary Case Management Guidelines – In Process
3. IDN 3 Adult CCSA Overview and Pathways Guidelines - Approved (see attachment\_B1.8av)
4. IDN 3 Youth CCSA Overview and Pathways Guidelines – Approved (see attachment\_B1.8avi)
5. IDN 3 Quality Measurement Protocols Guidelines- Approved (see attachment\_B1.8aiii)

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

1. IDN 3 Multi-Disciplinary Case Management Guidelines – In Process
2. IDN 3 Closed Loop Referral Guidelines - Approved (see attachment\_B1.8aiv)
3. IDN 3 Quality Measurement Protocols Guidelines- Approved (see attachment\_B1.8aiii)

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

1. IDN Notice to Medicaid Patients Information Sheet
2. IDN 3 Multi-Disciplinary Case Management Guidelines – In Process

Adherence to NH Board of Medicine guidelines on opioid prescribing:

1. SNHHS Prescribing Opioids For Mgmt/Treatment of Pain Checklist

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	Progress Not Met: No training was provided specifically related to universal screening and/or the IDN's Comprehensive Core Standardized Assessment (CCSA) during this reporting period. Training is being planned for early-mid 2018 for all levels of providers and care team members.	Progress Met: Dartmouth Hitchcock CCSA and SDOH Pathways learning session: 8 PCPs, 9 BHPs, and 6 care coordinators (March 2018) and Engaging Community Partners in Addressing Social Determinants of Health (DHHS/Myers and Stauffer): 6 PCPs, 1 BHP, and 1 care coordinator (May 2018).	<b>Not Achieved:</b> 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.
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.	Progress Met: 5 behavioral health providers, 2 peer support team members from HEARTS peer support center and 2 IDDT case managers from GNMHC team members were trained by Case Western Reserve University in December 2017 in the first two Stages of Treatment (engagement and persuasion) through the Case Western Integrated Dual Diagnosis Treatment (IDDT) training.	Progress Met: 5 behavioral health providers, 2 peer support team members from HEARTS peer support center and 2 IDDT case managers from GNMHC team members were trained by Case Western Reserve University in December 2017 in the first two Stages of Treatment (engagement and persuasion) through the Case Western Integrated Dual Diagnosis Treatment (IDDT) training.	<b>Not Achieved:</b> 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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	Progress Met: 5 primary care providers, 10 behavioral health providers and 4 care coordinators/case managers engaged in the IDN Fall Behavioral Health Conference, which included sessions such as Behavioral Health/SUD Language Training, Trauma-Informed Care, Supporting Someone with Behavioral Health Issues, and Spirituality in Behavioral Health.	Progress met: Peer support and recovery coach support training as part of full IDN monthly meeting (HEARTS and Revive Recovery Center): 3 PCPs, 1 BHP, 4 care coordinators (January 2018); Case management/NH WRAP-around program education as part of IDN SCP and Case Management Work Team meeting: 1 PCP, 8 BHPs, and 4 care coordinators (April 2018); and NH Healthy Families' patient portal/data analytics education as part of Full IDN monthly meeting: 3 PCPs, 5 BHPs and 3 care coordinators (April 2018).	<b>Achieved:</b> 63 total MDCT members received training across all reporting periods by 12/31/18
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.	Progress Met: 5 primary care providers, 10 behavioral health providers and 4 care coordinators/case managers engaged in the IDN Fall Behavioral Health Conference, which included sessions such as Behavioral Health/SUD Language Training, Trauma-Informed Care, Supporting Someone with Behavioral Health Issues, and Spirituality in Behavioral Health.	Progress met: Unpacking Assumptions (Ascentria Care Alliance): Monthly full IDN meeting (March 2018): 9 PCPs, 10 BHPs, 8 care coordinators; Lamprey Health staff meeting (May 2018): 22 PCPs, 2 BHPs, 0 care coordinators; Southern NH Health Grand Rounds (May 2018): 8 PCPs, 1 BHP. Stigma Across Cultures (Ascentria Care Alliance): Full IDN membership: 2 PCPs, 7 BHPs, 11 care coordinators (May 2018).	<b>Not Achieved:</b> <b>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 training platforms to increase the number of providers trained.</b>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	Progress Met: 5 primary care providers, 10 behavioral health care providers and 4 care coordinators/CHWs engaged in the IDN Fall Behavioral Health Conference, which included sessions such as The Role of the Brain in Addiction, Trauma-Informed Care, and Adolescent SBIRT.	Progress Met: Initial Training on Addiction (Case Western Reserve University): 4 PCPs, 13 BHPs, 10 care coordinators (January 2018) and American Society of Addiction Medicine (ASAM): 1 PCP, 4 BHPs and 10 community care coordinators (January 2018).	<del>Not</del> 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.
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.	Progress Not Met: The IDN CCSA and Referrals Work Team will begin developing the CCSA tool and process in early 2018.	Progress Met: The IDN CCSA and Referrals Work Team submitted an IDN 3 CCSA Tool and IDN Protocols/Guidelines to the IDN Clinical Governance Committee for approval in June 2018. With InteGreat Health, staff from both organizations have worked on a crosswalk of current visit protocol and CCSA domains to start to develop workflows for ensuring accurate collection of data from patient visits. Foundation Medical Partners has identified its sub-population and workflows to begin implementing the IDN CCSA tool with, which will begin in July 2018. DH will meet with its decision-makers in July to identify sources for all domains and finalize the workflows for its CCSA.	<del>Not</del> 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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	In Progress: Teams will begin to be formed in early 2018 in conjunction with the IDDT strategy and potentially the CTI strategy until the B1 practice strategies are implemented.	Progress Met: Dartmouth Hitchcock Nashua Family Medicine multi-disciplinary core team began case management in September 2017, engaging in more than 3,400 IDN Medicaid attributed patient encounters with 93% (3,198) completing pilot screenings (depression and substance use disorder) through the Dartmouth Hitchcock Substance Use and Mental Health Initiative (SUMHI).	<b>Achieved:</b> 11 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 Collective Medical Technologies' 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.	N/A	In Progress: Data sharing agreements and combination BAA/QSOAs have been executed as part of the IDN sub-contracting with GNMHC, allowing for direct contracting to now begin between GNMHC and CMT. The CMT PreManage ED solution has been being tested for in-bound and out-bound ADTs for the Southern NH Emergency Department and is expected to be live with data sharing with other emergency departments and urgent care sites around the state by July 2018.	<b>Not Achieved:</b> <b>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.</b>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	In Progress: Teams will begin to be formed in early 2018 in conjunction with the IDDT strategy and potentially the CTI strategy until the B1 practice strategies are implemented.	Progress Met: Dartmouth Hitchcock Nashua Family Medicine multi-disciplinary core team began case management in September 2017, which began as weekly case reviews related to screenings and interventions, as well as opportunities for primary care provider education opportunities. The CTI team (under GNMHC) has also engaged The Emmaus Institute, St. Joseph Hospital and other GNMHC programs (ACT, CSS, FEP) to conduct case management and strategize on interventions to support the addition of resources to support patient/client needs.	<b>Achieved:</b> 8 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.	Progress Not Met: InteGreat Health co-located pilot project had not yet begun accepting patients.	Progress met: Monthly meetings held between InteGreat Case Manager (GNMHC employee) and Clinical Care Coordinator (Lamprey Health employee) develop enhanced communication for InteGreat Health patient care management, but also to identify mechanisms for the tracking of referrals of InteGreat patients to other IDN 3 member agencies.	<b>Achieved:</b> InteGreat Health has exceeded 5 referrals to other organizations this reporting period

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	Progress Not Met: InteGreat Health co-located pilot project had not yet begun accepting patients.	Progress met: The majority of the referrals to InteGreat are coming from existing GNMHC & LHC patient panels, although one referral has been received from the International Institute of New England (IINE), which engages the IDN-funded Ascentria Care Alliance Community Healthy Worker. Plans are underway to educate IDN 3 providers about the services available and referral process through an Open House in the Fall 2018.	<b>Achieved:</b> InteGreat Health has received greater than 5 referrals from organizations outside of Lamprey & GNMHC
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 Collective Medical Technologies' Shared Care Plan platform by implementing the IDN protocols and guidelines for patient consent and secure information sharing.	Progress Met: 7 organizations participated in education and planning sessions conducted by CMT in October 2017, engaging in discussion for how the shared care plan and care guidelines for the EDs would be used for care coordination of the IDN attributed Medicaid population.	Progress met: Modification of current GNMHC and Lamprey Health HIT structure has occurred, including the workflows and protocols of the use of the two separate EHRs. The team is moving toward ways to interface the two EHRs and utilize the available IDN shared care plan platform through CMT to monitor and track diagnoses, goals and treatment plans for shared patients, which is expected by Fall 2018, with the final execution of the IDN BAA/QSOA and DUA with Lamprey (GNMHC has already executed these documents) and individual contracting with CMT.	<b>Not Achieved:</b> MDCTs are not yet leveraging CMT shared care plan platform

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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 Kno2 for their Direct Secure Messaging (DSM) platform, implementing the IDN protocols and guidelines for secure information sharing.	Progress met: the IDN members participated in an educational session with Kno2 in October 2017 to better understand the functionality and potential uses of the platform for Direct Secure Messaging (DSM).	Progress Met: Kno2 contracts were executed with Southern NH Health (for both Foundation Medical Partners and Southern NH Medical Center), with workflows currently in development for use of the platform. Workflows were developed and implemented for GNMHC/LHC patient care process and referrals to InteGreat Health with ongoing communication (upon patient completion of Release of Information) between clinical and IT staff teams of both agencies about the process for InteGreat PHI sharing.	<b>Not Achieved:</b> <b>7 IDN Member Entities executed Kno2 contracts by the end of the reporting period, with numerous others in the onboarding process and are expected to be operational in early 2019.</b>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	Progress Met: 38 out of 48 practices completed the Baseline SSA in June 2017, scoring a minimum of Level II on SAMHSA's Levels of Integrated Care, indicating their self-assessment of their practice being at Coordinated Care Practice designation.	Progress Met: more than 50 individuals attended the Cherokee Health/InteGreat Health Kick-off Event in March 2018, learning more about what integrated healthcare means and looks like. For the December 2017 SSAs (open period ending in January 2018), 16 practices completed the assessment. The SSA Provider Integration Team worked with the UNH Citizens Health Initiative to identify strategies for increasing participation in the June 2018 SSA, which included more targeted outreach to practices to engage them in completing the tool by the deadline. The IDN consultant called and emailed each individual practice, reminding them of the importance of this process for their practices to monitor and discuss their perspectives on integrated health within their practices.	<b>Achieved:</b> <ul style="list-style-type: none"> <li>• Achieved in prior reporting period: <ul style="list-style-type: none"> <li>○ 9 provider practices participated in the June '18 site self –assessment</li> <li>○ 19 provider practices participated in the Dec '17 site self -assessment</li> <li>○ 40 provider practices participated in the Jun '17 site self -assessment</li> </ul> </li> </ul> <p>6</p>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	In Progress: Community Health Worker positions are currently being advertised through the IDN's Career Board on its website, social media and other recruitment avenues through A1 project funds, including for Ascentria Care Alliance, Dartmouth Hitchcock (through their AmeriCorps VISTA funding). Other CHW positions are expected to be filled in early-mid 2018.	Progress Met: The Ascentria Care Alliance CHW served 11 refugees during the reporting period, providing care coordination and case management services. The Dartmouth Hitchcock AmeriCorps VISTA CHWs (Community Resource Corps) were also trained and placed with St. Joseph Hospital in their emergency department and with Nashua Department of Public Health to support public health activities related to substance use prevention in the IDN region.	<b>Achieved:</b> Ascentria Community Services added 15 new refugee/immigrant enrollments bringing to 18 the number of active cases
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	Progress Not Met: InteGreat Health co-located pilot project had not yet begun accepting patients.	Progress Met: 26 unduplicated patients were seen for primary care at InteGreat Health over 33 visits between 5/2/18 and 6/30/18.	<b>Achieved:</b> InteGreat Health saw 98 patients in this reporting period
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 Center will be targeted for referral into the InteGreat Health program as part of the co-located practice pilot.	Progress Not Met: InteGreat Health co-located pilot project had not yet begun accepting patients.	Progress Met: There have been 12 GNMHC patients seen by a Lamprey Health provider at InteGreat Health since May 2, 2018. The InteGreat Health Case Manager began in June to conduct an audit of the EMR to identify appropriate patients for care through InteGreat Health.	<b>Achieved:</b> InteGreat Health enrolled 54 GNMHC behavioral health patients

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	7/1/18-12/31/18
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.	Progress Not Met: InteGreat Health co-located pilot project had not yet begun accepting patients.	Progress Met: 5 LHC patients were referred for intake at GNMHC via InteGreat Health based upon screening/assessment results.	<b>Achieved:</b> InteGreat Health enrolled 44 primary care patients
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 Center (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.	Progress Not Met: InteGreat Health co-located pilot project had not yet begun accepting patients.	In Progress: With an open schedule for May and June, many patients were able to get same day/next week appointments for InteGreat Health with steps taken to expedite GNMHC intake for LHC referrals. A wait time tracking system is currently being explored by the GNMHC InteGreat Health Case Manager.	<b>Not Achieved:</b> 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
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 <b>within InteGreat Health program</b> by December 31, 2020.	Progress Not Met: measures-related data was not yet being extracted to MAeHC by IDN partners.	Progress met: 7 IDN attributed Medicaid patients received well-care checks between 5/2/18-6/30/18 through InteGreat Health.	<b>Progress Met:</b> The increase for well-care visits to InteGreat Health surpassed the 25% increase target

#### **B1-4. IDN Integrated Healthcare: 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
Physician's Assistant (Certified)	0.2	6	6.2	6.2	6.2
Psychiatrist/Psychiatric Advanced Practice Registered Nurse (APRN)	1.6	11	11	11	11
Consulting Pharmacist	0.1	20	20.1	20.1	20.1
Consulting Psychiatrist	0.2	3	3.2	3.2	.2
Psychiatric ARNP	0.5	6.4	6.4	6.4	6.4
Psychiatric Certified Nurse	1	0	0	0	0
Licensed Pastoral Psychotherapist	0.75	2	2.75	2.75	2.75

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
Master's Level Substance Use Disorder Therapist	1	16	17	17	17
Behavioral Health Clinician/Specialist (Master's Level)	5	5	5	6	6
Behavioral Health Case Manager (Bachelor's Level)	8	12	12	17.5	16
Behavioral Health Care Coordinator (Bachelor's Level)	5	63	63	63	63
Clinical Care Coordinator (Master's Level)	0.5	6	6	6.5	6.5
Clinical Operations	0.2	9	9.2	9.2	.2
Recovery/Transitional Care Case Manager	1	0.5	0.5	0.5	.5
Family Education and Peer Specialist	1	14	15	16	16
Training Coordinator	0.5	7	7.5	7.5	7.5
Peer Support Specialist	1	30	30	30	30
Community Health Worker	9	40	40	44	44
<b>Administrative Assistant</b>	<b>.75</b>	<b>27</b>	<b>27</b>	<b>27</b>	<b>27.75</b>
Front Office/Billing Support Staff	<b>1.3</b>	<b>290.5</b>	<b>290.5</b>	<b>290.8</b>	<b>290.8</b>

#### B1-4. IDN Integrated Healthcare: 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
Psychiatrist	1.95	.26	.26	.26	.31
Psychiatric Advanced Practice Registered Nurse (APRN)	1.3	0	0	.5	.5
Psychiatric Certified Nurse	1	0	0	0	0
Physician Assistant	.28	0	0	.28	.28
Nurse Practitioner	.28	0	0	0	.28
Registered Nurse	.5	0	0	0	.5
Consulting Pharmacist	.20	0	0	0	0
Medical Assistant	..28	0	0	.28	.28
Licensed Therapist	4.53	0	4.5	4.5	4.53
Master Licensed Alcohol and Drug Counselor	.03	0	0	0	.03
Behavioral Health Clinician/Specialist	7.6	0	3	2	3
Behavioral Health Coordinator	2	0	0	0	0
Case Manager	9.5	0	3	5	5

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
Care Coordinator	19.25	5	5	5	7.75
Community Health Worker	3.71	0	0	0	0
Criminal Justice Specialist/Liaison	.10	0	0	.10	.10
Supported Employment Specialist	.5	0	0	.5	0
Housing Specialist	.10	0	0	.10	.10
Family Specialist	.10	0	0	.10	.10
Peer Support Specialist	.5	0	0	0	0
Project Manager	.5	0	.5	.5	.5
Clinical Operations	.20	0	.20	.20	.20
IT Operations	.10	0	.10	.10	.10
Marketing/Education	.2	0	.2	.2	.2
Administrative Office/Billing/Patient Service Rep	1.62	0	.35	.62	.35

### 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. 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).

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): \$303,213.62

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$303,213.52
  - Jan – June 2018 actuals: \$33,279.00
  - July – December 2018 actuals: \$268,934.62

\*does not reflect all invoices expected from all IDN Member Entities for the July – December 2018 time frame.

Projections are displayed for the July to December 2018, as well as CY 2019, 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 NH Plus milestones/deliverables, as well as make progress along the SAMHSA Integrated Care Practice designation milestones/deliverables:

- Behavioral Health Specialist/Consultant (Master's Level): 4.6 FTEs
- Care Coordinator/Case Manager/Community Health Worker (up to Bachelor's Level): 11.2 FTEs
- Clinical Care Coordinator (Master's Level): .5 FTEs
- Psychiatric (Psychiatrist, Psychiatric APRN, Psychiatric Certified Nurse): 2.5 FTEs
- Physician Assistant: .2 FTEs
- Consulting Pharmacist: .10 FTE
- Clinical Operations: .20 FTEs
- Doctoral Level BH Therapist/Clinician: .5 FTEs
- Master's Level Licensed BH Therapist/Clinician: 1 FTE
- Program Evaluation Specialist (doctoral level specialist) .5 FTE
- Information Technology: .20 FTE (.10 each for GNMHC and LHC)
- Community Engagement: .10 FTE
- Billing/info support staff: .10 FTE
- InteGreat Project Manager: .5 FTE

Consultants to support:

- change management/technical assistance for co-located practice
- Open Access technology and changes in workflows

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 first year 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. 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.

Therefore, expenditures reflected in the budget table below reflect the following:

Employee salary/wages (including expenses such as supplies, equipment, travel/parking, printing/copying, software, occupancy, sub-contracts, etc. associated with salary/wages and benefits):

- GNMHC:
  - Marketing/communications staff time for InteGreat program
- Lamprey Health:
  - Marketing/communications staff time for InteGreat program

Consultants:

- MTM/National Council for Behavioral Health
  - Open Access gap analysis, training and technical assistance
- Pero Consulting
  - Project management for InteGreat and Open Access implementation, including project scoping and plan development, meeting facilitation for leadership and clinical operations, technical assistance and consultation
- Cherokee Health
  - Integrated Care training (3/29 – 3/30/17)

Equipment:

- Greater Nashua Mental Health Center/InteGreat Health:
  - Renovation costs, design services, movers for InteGreat practice space
  - Phone/fax line installation
  - Furniture: desks, chairs, file cabinets, sofas, door access panel/readers, copiers
- Lamprey Health/InteGreat Health:
  - Furniture: chairs, power strips

Current expenses (audit/legal):

- Greater Nashua Mental Health Center/InteGreat Health:
  - Integration with an FQHC, including MOU for shared space/lease
  - IDN sub-contract:
    - Master Agreement
    - Data sharing
- Lamprey Health/InteGreat Health:
  - IDN sub-contract:
    - Master Agreement

- Data sharing exhibit, including 42 CFR Part 2 components/considerations

Marketing and communications:

- GNMHC/Lamprey Health InteGreat Open House
  - signage and decorations
  - brochures for educating staff of each agency about the program and for staff to provide to clients to promote the program/support enrollment

Staff education and training:

- Greater Nashua Mental Health Center:
  - “Lost” staff time for training re: Open Access implementation

Other:

- Greater Nashua Mental Health Center:
  - Indirect costs, capped at 15% per the IDN 3 Finance Governance Committee for all IDN Member Entity sub-contracts

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

- Greater Nashua Mental Health Center/InteGreat Health:
  - Program Evaluation Specialist (.5 FTE)
  - Psychiatrist
    - Consulting (.20 FTE)
    - Core Team meeting (.025 FTE)
  - Case Manager (1 FTE)
  - Clinical Operations (.10 FTE)
  - Information Technology (.10 FTE)
  - Community Engagement (.10 FTE)

Consultants:

- Greater Nashua Mental Health Center:
  - Open Minds
    - Transition to value-based consulting

Current expenses (audit/legal):

- Lamprey Health/InteGreat Health:
  - Expenses associated with IDN sub-contracting

Marketing and communications:

- Greater Nashua Mental Health Center/InteGreat Health:
  - Materials with InteGreat logo

Other:

- Greater Nashua Mental Health Center:
  - Indirect costs, capped at 15% per the IDN 3 Finance Governance Committee for all IDN

Member Entity sub-contracts

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

- **B1-5a: IDN Integrated Healthcare**
  - **Budget Table**

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	Jan-June 2018 Actuals	July-Dec 2018 Projected	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	\$5,263,819.95	\$0.00	\$0.00	\$0.00	\$919,661.28	\$14,786.79	\$2,099,613.26	\$2,099,613.26	\$1,049,806.63	\$5,263,819.95
Employee Benefits	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Consultants	\$43,310.34	\$0.00	\$0.00	\$0.00	\$4,400.00	\$43,310.34	\$0.00	\$0.00	\$0.00	\$43,310.34
Equipment	\$195,729.21	\$0.00	\$0.00	\$17,363.00	\$0.00	\$178,366.21	\$0.00	\$0.00	\$0.00	\$195,729.21
Supplies (sum of lines below)	\$9,341.41	\$0.00	\$0.00	\$7,303.00	\$0.00	\$2,038.41	\$0.00	\$0.00	\$0.00	\$9,341.41
Educational		\$0.00	\$0.00	\$0.00						\$0.00
Medical/Lab/Pharmacy		\$0.00	\$0.00	\$0.00						\$0.00
Office		\$0.00	\$0.00	\$7,303.00		\$2,038.41				\$9,341.41
Travel (mileage/parking expenses)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Occupancy	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Current Expenses (sum of lines below)	\$18,953.50	\$0.00	\$0.00	\$8,613.00	\$0.00	\$10,340.50	\$0.00	\$0.00	\$0.00	\$18,953.50
Telephone		\$0.00	\$0.00	\$0.00						\$0.00
Internet costs		\$0.00	\$0.00	\$0.00						\$0.00
Postage		\$0.00	\$0.00	\$0.00						\$0.00
Printing and Copying		\$0.00	\$0.00	\$0.00						\$0.00
Audit and Legal		\$0.00	\$0.00	\$8,613.00		\$10,340.50				\$18,953.50
Insurance		\$0.00	\$0.00	\$0.00						\$0.00
Board Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Software	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Marketing/Communications	\$389.10	\$0.00	\$0.00	\$0.00	\$0.00	\$389.10	\$0.00	\$0.00	\$0.00	\$389.10
Staff Education and Training	\$19,703.17	\$0.00	\$0.00	\$0.00	\$0.00	\$19,703.17	\$0.00	\$0.00	\$0.00	\$19,703.17
Subcontracts/Agreements	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other (specific details mandatory):	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Recruitment Fees		\$0.00	\$0.00	\$0.00						\$0.00
Sign-on Bonus		\$0.00	\$0.00	\$0.00						\$0.00
Staff Referral Bonuses		\$0.00	\$0.00	\$0.00						\$0.00
Relocation Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Student Loan Repayment/Reimbursement		\$0.00	\$0.00	\$0.00						\$0.00
Employee Recognition/Retention Bonus		\$0.00	\$0.00	\$0.00						\$0.00
CMEs/Professional Development		\$0.00	\$0.00	\$0.00						\$0.00
Professional Development Fees/Dues		\$0.00	\$0.00	\$0.00						\$0.00
Staff Licensing/Certification Supervision Stipend		\$0.00	\$0.00	\$0.00						\$0.00
Other: please specify below	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>TOTAL</b>	<b>\$5,551,246.68</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$33,279.00</b>	<b>\$924,061.28</b>	<b>\$268,934.52</b>	<b>\$2,099,613.26</b>	<b>\$2,099,613.26</b>	<b>\$1,049,806.63</b>	<b>\$5,551,246.68</b>

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## 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.

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 Center	Y
Harbor Health/Harbor Care Health and Wellness Center	Y
Keystone Hall	Y
Lamprey Health Care	Y
<b>Lamora Psychological Associates</b>	<b>Y</b>
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 Center	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

Name	Title	Organization	Sign Off Received (Y/N)
Marilou Patalinjug Tyner	Chief Medical Officer	Greater Nashua Mental Health Center	Y
Cynthia Whitaker	Chief of Services	Greater Nashua Mental Health Center	Y
Susan Stearns	Deputy Director	NAMI NH	Y

## B1-8a. CCSA Domains

*See attachment\_B1.8a for table of all CCSA domains covered by IDN primary care and behavioral health provider practices/organizations.*

*See attachment\_B1.8ai for IDN 3 Adult CCSA Tool Paper Version\_07\_2018\_V2 document*

*See attachment\_B1.8aii for IDN 3 Youth CCSA Tool Paper Version\_11\_2018\_V1.1 document*

*See attachment\_B1.8aiii for IDN 3 Quality Measurement Protocols Guidelines document*

*See attachment\_B1.8aiv for IDN 3 Closed Loop Referral Guidelines document*

*See attachment\_B1.8av for IDN 3 Adult CCSA Overview and Pathways Guidelines document*

*See attachment\_B1.8avi for IDN 3 Youth CCSA Overview and Pathways Guidelines document*

The IDN 3 CCSA V1 was approved by the Clinical Governance Committee in June 2018. DHHS reviewed the approved IDN 3 CCSA tool (for ages 12 and over), requiring some modifications and approval of those modifications by the IDN Clinical Governance Committee, which was given in August. During October 2018, the IDN worked closely with the Youth Council to develop the Youth CCSA tool (for ages up to 14). In November, the IDN made available the approved version of the Youth CCSA tool to those partners servicing pediatrics and adolescents.

Most of our partners are using the IDN 3 CCSA tool either the paper version or an electronic version incorporated into their EHR Systems. However, providers are able to use their own tool that meets the domains required in the STCs. Any tools utilized beyond the IDN 3 tool or the DH tool are required to be submitted for approval by the IDN Clinical Governance Committee, along with submission of a crosswalk of their tool to ensure it covers the required domains. Lamprey Health completed this process and acquired Clinical Governance Committee approval for their tool in October.

The IDN published the following documents to support the implementation of the CCSA and addressing the 12 domains, provided the documents via separate emails and/or hard copies to GNMHC, FMP/SNHHS, St. Joseph Hospital, Lamprey, The Emmaus Institute, The Youth Council, LaMora, as well as presented and discussed CCSA execution flows and reporting expectations at several Full IDN meetings during this reporting period:

IDN 3 CCSA Tool covering all domains:

- IDN 3 Adult CCSA Tool Paper Version\_07\_2018\_V2 (see attachment\_B1.8ai)
- IDN 3 Youth CCSA Tool Paper Version\_11\_2018\_V1.1 (see attachment\_B1.8aii)

IDN 3 Outcome Measure Guidelines for all measures required to be reported by IDN partners based on DHHS DSRIP Outcome Measures Narrative v1.7 2018-11-08:

- IDN 3 Quality Measurement Protocols Guidelines (see attachment\_B1.8aiii)

IDN 3 Closed Loop Referral Guidelines:

- IDN 3 Closed Loop Referral Guidelines (see attachment\_B1.8aiv)

IDN 3 CCSA Overview and Pathways Guidelines and Recommendations:

- IDN 3 Adult CCSA Overview and Pathways Guidelines (see attachment\_B1.8av)
- IDN 3 Youth CCSA Overview and Pathways Guidelines (see attachment\_B1.8avi)

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

There were 11 multi-disciplinary core teams within IDN 3 identified during this reporting period. Determination of multi-disciplinary core team members across 32 primary care practices and additional behavioral health providers has posed a challenge for the IDN project team. The lack of fully clarity regarding the roles that make up an MDCT and the providers that must participate on an MDCT has resulted in a lost opportunity to finalize the MDCT member list. This delay has had multiple implications including lack of full accounting of training participation by all MDCT members (including non-direct staff) as well as identification of the frequency and protocols used within 11+ MDCT recurring care coordination meetings. The targets related to MDCT training have not yet been achieved but what has been identified is likely lower than actual participation rates due to not having a fully confirmed list of MDCT names to track to. This gap is glaring when reviewing the supporting MDCT non-direct staff training participation rates. The aggregated list (B1.8d attachment) is primarily blank for participation. Similar to the MDCT members likely having participated in training far more than captured (B1.8c attachment), the non-direct staff are in the same situation – trained yet not captured in many cases.

To support mitigation of the implications of the delay in MDCT identification, IDN 3 partner liaisons are being tasked to ensure their partner points of contact have a full understanding of the criteria of MDCT members, identify them by name, and gain information regarding their recurring care management meetings.

MDCT Team #	Proposed IDN Provider Practices with Pilot Multi-Disciplinary Core Team (MDCT)	MDCT Member On-Boarding Status
<b>Dartmouth Hitchcock (DH) Practices</b>		
1	DH Nashua Family Medicine	
	DH Nashua Pediatrics - future state to be part of DH Family Medicine MDCT	
	Provider, MD	Existing
	Behavioral Health Clinician, LICSW	Existing
	Community Health Worker, MSW	Existing
	Nurse Care Coordinator, RN	Existing
2	Psychiatrist, MD	Existing
	DH Nashua Internal Medicine	Go-live scheduled for 4/1/19
	Provider, MD (PCP)	Existing
	Behavioral Health Clinician, LICSW (BH)	Existing
	Community Health Worker, MSW (CC)	Existing
	Nurse Care Coordinator, RN (CC)	Existing
3	Nurse Care Coordinator, RN (CC)	Existing
	Psychiatrist, MD (BH)	Existing
	DH Hudson	Future state

	DH Milford	Future state
	DH Merrimack	Future state
	Behavioral Health Clinician, LICSW (BH)	Existing
	Community Health Worker, MSW (CC)	awaiting funding
	Nurse Care Coordinator, RN (CC)	awaiting funding
	Nurse Care Coordinator, RN (CC)	Existing
	Psychiatrist, MD (BH)--currently same individual as above	Existing
	Psychiatrist, MD	Existing
<b>Foundation Medical Partners (FMP) Practices</b>		
4	Amherst Family Practice	
	Milford Family Practice	
	South Nashua Family Practice	
	Hudson Family Practice	
	Pelham Family Medicine	
	Provider, MD	Existing
	Psychiatric APRN (shared across multiple practices)	Existing
	Behavioral Health Clinician/Social Worker, LICSW	Existing
	Embedded Care Coordinator, RN	Existing
5	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	
	Provider, MD	Existing
	Psychiatric APRN (shared across multiple practices)	Existing
	Behavioral Health Clinician/Social Worker, LICSW/MLADC	Existing
	Embedded Care Coordinator, RN	Existing
6	Medicine-Pediatrics of Nashua	
	Foundation Pediatrics	
	Main St. Pediatrics & Adolescent Medicine	
	Provider, MD	Existing
	Pediatric Psychiatrist/Psychiatric APRN	To be Hired
	Behavioral Health Clinician/Social Worker, LICSW/LCMHC	To be Hired
	Embedded Care Coordinator, RN	Existing
<b>Greater Nashua Mental Health Center: CTI and IDDT Teams</b>		
<b>MDCT participant</b>	Critical Time Intervention (CTI)	
	Team Coordinator/Team Lead, Master's Level	Existing
	Case Manager (Specialist)	Existing
	Case Manager (Specialist)	Existing
	Intellectual/Developmental Disabilities Clinical Consultant	Existing
	Spirituality Behavioral Health Clinical Consultant, LPP	Existing
<b>MDCT participant</b>	Integrated Dual Diagnosis Treatment (IDDT)	
	Team Coordinator/Team Lead, Master's Level	Existing
	Dual Diagnosis Therapist, Psy.D.	Existing
	Dual Diagnosis Therapist, Psy.D.	Existing
	Psychiatric APRN	Existing
	Case Manager, BA	Existing
	Case Manager, BA	Existing
	Nurse, RN	Existing

	Supported Employment Specialist, MBA	Existing
<b>7</b>	<b>InteGreat Health co-located pilot between Lamprey Health and GNMHC</b>	
	Provider, MD	Current at Lamprey Health
	Consulting Psychiatrist, MD	Current at GNMHC
	Physician Assistant, PA	Current at Lamprey Health
	Physician Assistant, PA	Current at Lamprey Health
	SUD Clinician, MLADC	Current at GNMHC
	BH Clinician, LCMHC	Current at GNMHC
	Clinical Care Coordinator, MSW	Current at Lamprey Health
	Integrated Care Case Manager, BA	Current at GNMHC
	Community Health Worker	expected to be hired Q1 2019
	Clinical Operations	Current Lamprey Health & GNMHC
<b>MDCT participant</b>	<b>LaMora Psych Associates</b>	
	MLADC, LICSW, PHD (BH)	Existing
<b>8</b>	<b>Lamprey Health</b>	
	Provider, MD (PCP)	Existing
	Consulting Psychiatrist, MD (BH)	Existing
	Physician Assistant, PA-C (PCP)	Existing
	Care Coordinator, BA (CC)	Existing
	Community Health Worker (CC)	Existing
	Clinical Operations Management (Non-Direct Care Staff)	Existing
<b>MDCT participant</b>	<b>Merrimack River Medical Services</b>	
	Provider, MD	Current
	Social Worker, LICSW	Current
	SUD Therapist, MLADC	Current
	Psychiatric APRN	To potentially be contracted through Harbor Homes or another IDN Member Entity provider
	Certified Recovery Social Worker (CRSW), Peer Support Specialist, or Community Health Worker (TBD)	to be on-boarded by Fall 2018
	<b>Partnership for Successful Living coordinated care across Harbor Homes, Keystone Hall and Healthy at Home</b>	
<b>9</b>	<b>Harbor Health/Harbor Care Health and Wellness Center</b>	
	Provider, MD	Current
	Psychiatric APRN	Current
	Integrated Care Case Manager, BA	to be on-boarded
	Community Health Worker	to be on-boarded
<b>MDCT participant</b>	<b>Keystone Hall</b>	
	Integrated Care Case Manager, BA	to be on-boarded
	Care Coordinator, BA	to be on-boarded
<b>MDCT participant</b>	<b>Healthy at Home</b>	
	Psychiatric Certified Nurse	to be on-boarded
	Integrated Care Case Manager, BA	to be on-boarded
	<b>St. Joseph Hospital and Physician Practices (SJH)</b>	
<b>10</b>	<b>SJH Pediatrics Nashua</b>	
	<b>SJH Pediatrics Milford</b>	
	<b>SJH Pediatrics Sky Meadow</b>	
	Provider, MD/PA	Current
	Provider, NP	Current

	Embedded Behavioral Health Consultant, Master's Level Licensed Clinician	internal or contracted through GNMHC--TBD
	Pediatric Psychiatrist/Psychiatric APRN (BH)	tbd
	Nurse Care Coordinator	Current
11	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	
	Provider, MD	Current
	Provider, NP	Current
	Embedded Behavioral Health Consultant, Master's Level Licensed Clinician	internal or contracted through GNMHC--TBD
	Adult Psychiatrist/APRN	internal or contracted through GNMHC--TBD
	Nurse Care Coordinator, RN	Current
<b>MDCT participant</b>	<b>The Emmaus Institute</b>	
	Licensed Pastoral Psychotherapists	Current
	Licensed Pastoral Psychotherapists	Current
<b>MDCT participant</b>	<b>The Youth Council</b>	
	Master's Level Student Assistance Counselor	Current
	Master's Level Student Assistance Counselor	Current
	BH Clinician, MLADC, LICSW	Current

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

The following trainings were taken into consideration in the tracking and aggregation of participation by multi-disciplinary core team members. The trainings executed heavily leaned toward cultural competency topics due to the support of funding for a trainer whose area of expertise is on this topic and has contractual agreements to provide multiple training opportunities to IDN member partners both in public forums as well as onsite at each organization. This focus has clearly provided sufficient opportunities that have been taken advantage of. The IDN Admin team have learned from this approach and are planning on focusing additional time and resources on ensuring a more diverse offering of trainings to the IDN partner members. The details behind this mitigation plan were highlighted in A1-3.

As noted in the narrative within A1-3, gaining engagement in training by multi-disciplinary core team members continues to be a challenge as will be noted in the following attachment. As also noted, there are already changes in place to support a higher level of focus on engaging partners in required trainings particularly for the MDCT.

*See attachment\_B1.8c: Multi-Disciplinary Core Team Member Providers Trained*

IDN3 Trainings July - December, 2018							
Training Category	TRAINING NAME	Date	TOTAL ATTENDEES	MDCT Primary Care	MDCT Behavioral Health	MDCT Care Coordinators/ Case Mgrs	All Other Non-MDCT + Non-Direct Care Staff
CM	Advance Motivational Interviewing	7/30/2018	12		1	1	10
CM	Basic Motivational Interviewing	10/4/2018	21			8	13
COD	Intersection of Chronic Disease/BH	10/31/2018 and 12/12/2018	20			5	15
MHA	Adult Mental Health First Aid	11/05/2018 and 12/3/2018	26			9	9
CC	Unpacking Assumptions	9/12/2018	47			3	15
CC	Unpacking Assumptions	9/24/2018	33			1	15
CC	Unpacking Assumptions	10/18/2018	15				15
CC	Unpacking Assumptions	12/5/2018	11		3		8
CC	Stigma Across Cultures	11/2/2018	8		1		7
CC	Ethics & Cultural Competency Skills	7/10/2018	15				15
CC	Ethics & Cultural Competency Skills	7/18/2018	38				38
CC	Ethics & Cultural Competency Skills	7/26/2018	27				27
CC	Ethics & Cultural Competency Skills	8/14/2018	16				16
CC	Ethics & Cultural Competency Skills	8/15/2018	8				8
CCSA	CCSA Training	8/23/2018	16		1	1	14
MISC	days)	12/10/18; 12/22/18	21	5	17	11	
MISC	PHAC		20+	not able to identify workshops specifically attended not acceptable to count towards training topic not applicable to MDCT training topic not applicable to MDCT training topic not applicable to MDCT training			
MISC	M&S monthly B1 integrations	monthly					
MISC	- Sustainability	11/14/2018	11				
MISC	- Performance Measures	8/1/2018	19				
MISC	CHI Annual Symposium	9/19/2018					
MISC	IDN sponsored	numerous					
CM: Case Management/Care Coordination							
CCSA: CCSA/Universal Screening							
CC: Cultural Competency							
COD: Co-Occurring Disorders							
UA: Understanding Addiction							
MHA: Mental Health Awareness/Mental Health First Aid							
PR: Secure Data Sharing and Patient Privacy							
IS: Information Sharing Platforms							

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

See attachment\_B1.8d: Non-Direct Care Providers Trained

Non-Direct Staff were not clearly identified as part of multi-disciplinary core teams hence the tracking of their training participation was not captured accurately and resulted in poor outcomes.

MDCT Team #	Practice Name	Total Number of Non-Direct Care Providers to be Trained	Total Trained	Mental Health First Aid: # Trained			Addressing Challenges with Coding: # Trained			Cultural Competency: # Trained			
				Jul-Dec '17	Jan-Jun '18	Jul-Dec '18	Jul-Dec '17	Jan-Jun '18	Jul-Dec '18	Jul-Dec '17	Jan-Jun '18	Jul-Dec '18	
	<b>Dartmouth Hitchcock</b>												
1	DH Nashua: Family Practice, Internal Medicine and Pediatrics	Up to 27											
2	DH Internal Medicine	Up to 27											
3	DH: Hudson, Milford and Merrimack	Up to 27											
	<b>Foundation Medical Partners</b>												
4	Amherst Family Practice	Up to 9											
	Milford Family Practice	Up to 21											
	South Nashua Family Practice	Up to 9											
	Hudson Family Practice	Up to 21											
	Pelham Family Medicine	Up to 18											
5	Downtown Medical Associates	Up to 12											
	Internal Medicine Associates of Nashua	Up to 12											
	Merrimack Medical Center	Up to 9											
	Nashua Primary Care	Up to 15											
	Nashua West Adult Medicine	Up to 18											
6	Internal Medicine at Pelham Medical Center	Up to 9											
	Foundation Internal Medicine	Up to 9											
	Medicine-Pediatrics of Nashua	Up to 18											
	Main St. Pediatrics & Adolescent Medicine	Up to 6											
MDCT participant	Greater Nashua Mental Health Center	Up to 69											
	Foundation Pediatrics	Up to 24											
7	InteGreat Health												2
8	Lamprey Health Care	Up to 9											
MDCT participant	Merrimack River Medical Services	Up to 12											
	<b>Partnership for Successful Living</b>												
9	Harbor Health/Harbor Care Health and Wellness Center	Up to 162											
MDCT participant	Keystone Hall	Up to 12											
MDCT participant	Healthy at Home	Up to 9											
	<b>St. Joseph Hospital and Physician Practices</b>												
10	SJH Pediatrics Nashua, Milford and Sky Meadow	Up to 27											
11	SJH Family Medicine Nashua, Internal Medicine and Adult Medicine; SJH Family Medicine and Speciality Services: Hudson, Merrimack and Milford	Up to 123											
	MDCT participant	The Emmaus Institute	Up to 9										
MDCT participant	The Youth Council	Up to 9											

**B1-8e. Monthly Case Conference Schedule**

As noted above in B1-8b, multi-disciplinary teams continue to evolve although there are several teams that have their monthly (if not more frequent) case conference schedules in flight.

MDCT Team #	Proposed IDN Provider Practices with Pilot Multi-Disciplinary Core Team (MDCT)	Case Management Meeting Schedule
	<b>Dartmouth Hitchcock (DH) Practices</b>	
1	DH Nashua Family Medicine	weekly
	DH Nashua Pediatrics – future state to be part of above MDCT	
2	DH Nashua Internal Medicine	go-live expected 4/1/19
3	DH Hudson	future state
	DH Milford	
	DH Merrimack	
	<b>Foundation Medical Partners (FMP) Practices</b>	

4	Amherst Family Practice	monthly
	Milford Family Practice	
	South Nashua Family Practice	
	Hudson Family Practice	
	Pelham Family Medicine	
5	Downtown Medical Associates	monthly
	Internal Medicine Associates of Nashua	
	Merrimack Medical Center	
	Nashua Primary Care	
	Nashua West Adult Medicine	
	Internal Medicine at Pelham Medical Center	
	Foundation Internal Medicine	
6	Medicine-Pediatrics of Nashua	monthly
	Foundation Pediatrics	
	Main St. Pediatrics & Adolescent Medicine	
	<b>Greater Nashua Mental Health Center: CTI and IDDT Teams</b>	
<i>MDCT participant</i>	Critical Time Intervention (CTI)	as requested
<i>MDCT participant</i>	Integrated Dual Diagnosis Treatment (IDDT)	as requested
7	<b>InteGreat Health co-located pilot between Lamprey Health and GNMHC</b>	weekly - Wednesdays
<i>MDCT participant</i>	<b>LaMora Psych Associates</b>	as requested
8	<b>Lamprey Health</b>	1st Monday/month
<i>MDCT participant</i>	<b>Merrimack River Medical Services</b>	as requested
	<b>Partnership for Successful Living coordinated care across Harbor Homes, Keystone Hall and Healthy at Home</b>	
9	Harbor Health/Harbor Care Health and Wellness Center	future state
<i>MDCT participant</i>	Keystone Hall	as requested
<i>MDCT participant</i>	Healthy at Home	as requested
	<b>St. Joseph Hospital and Physician Practices (SJH)</b>	
10	SJH Pediatrics Nashua	monthly
	SJH Pediatrics Milford	
	SJH Pediatrics Sky Meadow	
11	SJH Family Medicine, Nashua	monthly
	SJH Internal Medicine	
	SJH Family Medicine & Specialty Services Hudson	
	SJH Family Medicine & Specialty Services Merrimack	
	SJH Family Medicine & Specialty Services Milford	
	SJH Adult Medicine	
<i>MDCT participant</i>	<b>The Emmaus Institute</b>	as requested
<i>MDCT participant</i>	<b>The Youth Council</b>	as requested

## **B1-8f. Direct Secure Messaging**

As a part of the Statewide HIT Taskforce recommendations for each IDN to meet as a minimum capability/standard for the ability to transmit patient information between providers, IDN 3 is asking each IDN Member Entity to ensure they have direct secure messaging capabilities via:

- Contracting with Kno2 directly, IDN 3's DSM Vendor
- DSM capabilities as part of certified EHR system such as CareConnect DH which is set up to do Direct Secure Messaging within DH's Epic system
- Another vendor other than Kno2 who provides DSM capabilities

Nine of our partners have the ability to send direct secure messages through their existing EHR as part of integrated direct secure messaging:

1. Southern NH Medical Center
2. Foundation Medical Partners
3. Dartmouth Hitchcock
4. St. Joseph Hospital
5. St. Joseph Hospital and Physician Practices
6. Lamprey Health
7. Merrimack River Medical Services
8. New Hampshire Hospital
9. Harbor Homes

Seven organizations have executed contracts with Kno2 during the reporting period and will submit DSM attestation forms along with their invoicing:

1. Ascentria
2. Crotched Mountain
3. Greater Nashua Mental Health Center (GNMHC)
4. Home Health and Hospice
5. NAMI NH
6. LaMora Psychological Associates
7. Life Coping

### *Barriers/Challenges and Mitigation Plans:*

Even though there was significant progress in this area, the following are some of the challenges faced in procuring Kno2:

- Kno2 Pricing Model Change:
  - Challenge: We were notified in late Q3 of 2018 that the pricing model had changed for Kno2 from what was budgeted for the entire waiver period based on NHHIO licensing which expired end of June of 2018. On 10/30/18, Kno2 did a refresher demonstration to the Data/IT Governance Committee and the IDN was informed that Kno2 will be incorporating Closed Loop Referral functionalities into their product to be available later in Q1 2019. The process of re-negotiating, approval from both legal and the Finance Committee has carried over to January of 2019. This has impacted actual execution of Kno2 for those providers who hadn't already contracted with Kno2 before the NHHIO licensing expired

- Mitigation: This was brought to the Data/IT Committee to see if the committee wanted to consider another vendor or re-negotiate with Kno2. The decision was to re-negotiate and explore an IDN sponsorship agreement with Kno2 vs the current model where each provider sub-contracting with Kno2 directly and then completing an Attestation and Invoicing the IDN based on the budgeted amount for each provider. The IDN expects this process to be completed early Q1 2019 and expect already engaged partners to get Kno2 quickly thereafter.
- Workflow change concerns:
  - Challenge: 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 Kno2 for interoperability before impacting their workflows.
  - Mitigation: As partners have been coming on board, the partner liaisons have been working with their partners to document either already established or identify workflow changes needed to support DSM. The intent and messaging has been to minimize these changes with support from the Kno2 tool such as when a DSM message arrives, the tool is able to forward notification to existing email systems that there is a DSM message waiting so that staff does not have to constantly monitor the DSM mailbox.

## **B1-8g. Closed Loop Referrals Narrative**

The IDN has utilized the guidance provided by Myers and Stauffer to draft initial protocols and guidance for closed loop referrals, including requesting workflows and protocols from individual provider organizations as we finalized SFY 19 sub-contracts. On 07/12/18 and 08/09/18, the CCSA and Referrals Work Team met to review and discuss the CCSA process workflows. On 08/22/18, the IDN gathered feedback via a questionnaire from our partners of their current referral pathways and best practices for closing those referral loops. These were all incorporated into the Youth and Adult *IDN 3 CCSA Overview and Pathways Guidelines (see attachment\_B1.8av and attachment\_B1.8avi)*, presented to the Clinical Governance Committee on High level discussions at Clinical Gov. Committee meeting on 12/17/18 and subsequently approved on 01/14/19.

The following are the minimum recommended IDN 3 guidelines for closing the loop for a normal flow:

a. *The Receiving Provider:*

- Once the patient/client is seen by the receiving provider, the receiving provider sends one or more of 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”
- If shared care plan (SCP) available, ideally, the receiving provider also updates outcomes & follow-up plan in SCP

b. *The Referring Provider:*

- Documents outcome provided by receiving provider either manually or electronically in an EHR system whether that is automated or needs some manual interventions.
- If shared care plan (SCP) available, review updates to SCP & follow-up with patient if needed

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.

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

*See attachment\_B1.8hi for IDN 3 IDN Notice to Medicaid Patients Information Sheet*

*See attachment\_B1.8hii for SNHHS Prescribing Opioids For Mgmt/Treatment of Pain Checklist*

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

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

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

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

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

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

Although progress has been made towards Coordinated Care designation, no partner providers achieved this goal during this reporting period. The progress noted elsewhere in this report highlights the evolution of identification of multi-disciplinary teams, finalization of the CCSA and implementation plans, development of protocols, guidelines and workflows, implementation across the IDN 3 partner

landscape while also calling out the barriers experienced and the mitigation plans to support a concerted effort to engage practices, at the provider level, to rapidly advance this achievement.

As noted within the PPI section of this report, the plan is to leverage the development of partner-specific work plans, rely on the assigned partner liaisons to support keeping partners on track for deliverables and lastly to leverage the project dashboards which provide partner level detail as to progression towards coordinated care.

### **B1-9b. Additional Integration Care Practice designation requirements**

InteGreat Health, as a collaboration between Lamprey Health and Greater Nashua Mental Health Center, continue to evolve their integrated practice approach. They have recently begun to explore sharing of information via a common document management platform thereby allowing ability to view patient information not via their silo'd existing EHR's but instead through a common repository. This solution is anticipated to roll out in this upcoming reporting period. They continue their recurring care meetings on a weekly basis each day they hold InteGreat office hours thereby allowing timely communication and interaction regarding their complex patients.

The additional evidence based interventions of Medication-assisted treatment (MAT) and evidence-based treatment of mild-to-moderate depression are not in use and protocols have yet to be identified or reviewed by the IDN Admin team for attestation hence there are no submissions provided.

### **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**

There has been progress with providers in working through joint service protocols and communication channels with and among community-based social services support providers. These workflows and protocols have been shared with the IDN and are satisfactory in meeting the protocols/guidelines as identified by its Clinical Governance Committee. These include:

InteGreat Health (Lamprey and GNMHC):

- The International Institute of New England and Ascentria Care Alliance to refer new immigrants/refugees without primary care providers to InteGreat Health.
- The Youth Council IMPACT program referring youth without primary care providers to InteGreat Health.

The Youth Council:

- Grow Nashua
- Family Connections Committee
- YMCA of Greater Nashua

GNMHC:

- NH Hospital's social work department/discharge coordinator
- SNHMC's BHU discharge coordinator/transitional care coordinator

SNHMC:

- The ED Transitional Care Coordinator has workflows in place for her behavioral health assessments between the hospital and the IDN partner members

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

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

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

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

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

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

Achieved	Total Goal Number Designated	Baseline Designated 6/30/17	Number Designated 12/31/17	Number Designated 6/30/18	Number Designated 12/31/18
Coordinated Care Practice	34 39	0	1 0	1 0	0
Integrated Care Practice	2	0	0	0	0

Progress Toward Coordinated Care Practice	List of providers identified to make progress toward Coordinated Care Practice designation	12/31/17	6/30/18	12/31/18
	<p>Dartmouth Hitchcock (DH) Nashua Family Medicine                      DH Nashua Internal Medicine                      DH Hudson                      DH Merrimack                      DH Milford                      DH Nashua Pediatrics</p> <p>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</p> <p>Greater Nashua Mental Health Center</p> <p>Harbor Homes</p>		<p>In Progress:</p> <ul style="list-style-type: none"> <li>Greater Nashua Mental Health Center implementing CCSA during reporting period (per approval of ANSA-based CCSA tool in June 2018)</li> <li>FMP expected to implement CCSA with Complex Care Management target sub-population by October 2018</li> <li>Lamprey Health expected to get CCSA approved by October 2018 and begin implementation of process</li> <li>The Youth Council</li> </ul>	<p><b>Not Achieved</b>                      No providers achieved Coordinated Care designation</p>

	<p>Healthy at Home</p> <p>Keystone Hall</p> <p>LaMora Psychological Associates</p> <p>Lamprey Health</p> <p>Merrimack River Medical Services</p> <p>St. Joseph Hospital &amp; Physician Practices (SJH): Pediatrics Nashua</p> <ul style="list-style-type: none"> <li>SJH Pediatrics Milford</li> <li>SJH Pediatrics Sky Meadow</li> <li>SJH Family Medicine, Nashua</li> <li>SJH Internal Medicine</li> <li>SJH Family Medicine and Specialty Services Hudson</li> <li>SJH Family Medicine and Specialty Services Merrimack</li> <li>SJH Family Medicine and Specialty Services Milford</li> <li>SJH Adult Medicine</li> </ul> <p>The Emmaus Institute</p> <p>The Youth Council</p>		<p>expected to begin implementing CCSA with youth as part of referral to higher level of services with MLADC/LICSW</p> <ul style="list-style-type: none"> <li>• The Emmaus Institute expected to begin implementing IDN 3 CCSA tool by October 2018</li> </ul> <p>Progress Not Met:</p> <ul style="list-style-type: none"> <li>• Merrimack River Medical expected to make progress beginning fall 2018 once approval has been provided by their newly merged partner (Baymark) has provided approval</li> <li>• SJH expected to get CCSA tool approved by IDN Clinical Governance Committee by October 2018, with expected support from their newly merged partner (Covenant) has provided approval</li> </ul>	
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<b>Progress Toward Integrated</b>	<b>List of providers identified to make progress toward Integrated Care Practice designation</b>	<b>12/31/17</b>	<b>6/30/18</b>	<b>12/31/18</b>
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Care Practice				
	<p>Dartmouth Hitchcock (DH) Nashua Family Medicine  DH Nashua Internal Medicine  DH Hudson  DH Merrimack  DH Milford  DH Nashua Pediatrics</p> <p>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</p> <p>Greater Nashua Mental Health Center</p> <p>Harbor Homes</p> <p>Healthy at Home</p> <p>Keystone Hall</p> <p>LaMora Psychological Associates</p> <p>Lamprey Health</p> <p>Merrimack River Medical Services</p> <p>St. Joseph Hospital &amp; 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</p>			<p><b>Not Achieved</b>  No providers achieved Integrated Care designation</p>

	SJH Family Medicine and Specialty Services Milford SJH Adult Medicine  The Emmaus Institute  The Youth Council			
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## ***B1 Integrated Health: Attachments***

attachment\_B1.2a: IDN Integrated Healthcare Implementation Plan Table

attachment\_B1.8a: CCSA Domains Covered by IDN Primary Care and Behavioral Health Provider Practices/Organizations

attachment\_B1.8ai for IDN 3 Adult CCSA Tool Paper Version\_07\_2018\_V2 document

attachment\_B1.8aia for IDN 3 Youth CCSA Tool Paper Version\_11\_2018\_V1.1 document

attachment\_B1.8aiii for IDN 3 Quality Measurement Protocols Guidelines document

attachment\_B1.8aiv for IDN 3 Closed Loop Referral Guidelines document

attachment\_B1.8av for IDN 3 Adult CCSA Overview and Pathways Guidelines document

attachment\_B1.8avi for IDN 3 Youth CCSA Overview and Pathways Guidelines document

attachment\_B1.8c: Multi-Disciplinary Core Team Member Providers Trained

attachment\_B1.8hi for IDN 3 IDN Notice to Medicaid Patients Information Sheet

attachment\_B1.8hii for SNHHS Prescribing Opioids For Mgmt/Treatment of Pain Checklist

attachment\_B1.9c: IDN Member Entity Provider Use of Technology

Status	Task Name	Comments
Completed	Stage 1: Project Planning and Progress Milestones (Development of Implementation Plan) January to June 2017	
Completed	I. Develop Implementation Timeline	
Completed	A. Practices identified to move toward Coordinated Care Practice designation	
Completed	B. Practices identified to move toward Integrated Care Practice designation	
Completed	II. Complete Project Budget	
Completed	A. Develop and submit budgets through IDN Governance Committee decision-making structure	
Completed	B. Executive Committee signs off on plan	
Completed	III. Outline Workforce Staffing Plan	
Completed	A. Identify staffing needs for practices to achieve Coordinated Care Practice and move toward Integrated Care Practice designation	
Completed	IV. Identify Key Organizational/Provider Participants	
Completed	A. Secure signed Letters of Agreement from IDN Practice Managers	
Completed	V. Secure Organizational Leadership Sign-Off	
Completed	A. Executive Committee approves implementation plans	
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	A. Conduct gap analysis of assessment and screening tools used by partners	
Completed	A1. Complete work sessions and/or interviews with IDN partners to identify existing screening/assessment tools used	
Completed	A2. Initiate the identification of workflows where existing assessments and screenings are utilized by IDN partners	
Completed	B. Engage IDN members through development and work of CCSA and Referrals Work Team to identify/develop IDN 3 CCSA	
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	A1. Participate in vendor demos with other IDNs	
Completed	A2. Complete voting process with IDN Governance Committees for IDN 3 vendor platform	
Completed	B. Identification of clinical workflow between providers using SCP	
Completed	B1. Identification of pilot users of SCP and level of access through CMT platform	
Completed	III. Identify/develop protocols for patient assessment, treatment, management	
Completed	A. IDN Clinical Governance Committee identifies/develops IDN recommended protocols and/or guidelines	
Completed	B. IDN member entities outline protocols through development of their Scope of Work (SOW) in the IDN sub-contract	
Completed	B1. IDN Member Entities approved for funding from IDN Governance Committees provide protocols in SOW for review by IDN Administrative Lead	
Completed	B2. IDN Administrative Lead provides feedback and guidance for integrating protocols across provider organizations across the IDN	
Completed	IV. Identify/develop patient referral protocols including to those to/from PCPs, BH providers, social service support providers, hospitals and EDs	
Completed	A. IDN Clinical Governance Committee identifies/develops IDN recommended protocols and/or guidelines	
Completed	B. IDN members entities outline referral protocols through development of their Scope of Work (SOW) in the IDN sub-contract	
Completed	B1. IDN Member Entities approved for funding from IDN Governance Committees provide protocols in SOW for review by IDN Administrative Lead	
Completed	B2. IDN Administrative Lead provides feedback and guidance for integrating protocols across provider organizations across the IDN	
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	A. IDN Clinical Governance Committee identifies/develops IDN recommended protocols and/or guidelines for communication and use of care plan sharing	
Completed	B. IDN members entities outline core team meeting/communication plan and workflows for communication with patient's care team through development of their Scope of Work (SOW) in the IDN sub-contract	
Completed	B1. IDN Member Entities approved for funding from IDN Governance Committees provide protocols in SOW for review by IDN Administrative Lead	
Completed	B2. IDN Administrative Lead provides feedback and guidance for integrating protocols across provider organizations across the IDN	
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	
Completed	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	B1. IDN Member Entities approved for funding from IDN Governance Committees provide protocols in SOW for review by IDN Administrative Lead	
Completed	B2. IDN Administrative Lead provides feedback and guidance for integrating protocols across provider organizations across the IDN	
Completed	VII. Identify/develop training plan for each member of the core team and extended team as needed	
Completed	A. Physical health team member training plan developed	
Completed	B. Behavioral health team member training developed	
Completed	C. Care coordinators, case managers, and/or Community Health Work team member training developed	
Completed	D. Front desk/billing staff team member training developed	
Completed	VIII. Identify/develop training curricula for each member of the core team and extended team as needed	
Completed	A. Physical health team member training curricula identified	
Completed	B. Behavioral health team member training provider curricula identified	
Completed	C. Care Coordinators, Case Managers, and/or Community Health Worker team member training curricula identified	
Completed	D. Front desk/billing staff team member training provider curricula identified	
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	
Completed	A. Participating providers and organizations identified for each project strategy	
Completed	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	
Completed	A. Adoption of Coordinated Care Practice designation strategies by IDN primary care and behavioral health providers	

Status	Task Name	Comments
Completed	B. Movement toward adoption of Integrated Care Practice designation strategies by IDN primary care and behavioral health providers	
Completed	XI. Identify/develop mechanisms (e.g., registries) to track and monitor individuals served by the program, adherence, impact measures, and fidelity to integration framework	
Completed	A. IDN provider organizations create workflows and protocols for utilizing their EHRs to track and monitor individuals served by the project strategies	
Completed	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	<b>Stage 1: Project Utilization Milestones (Continued Progress Demonstrated for SAMHSA Integrated Levels of Care) July - December 2017</b>	
Completed	I. Implementation of workforce plan	
Completed	A. Implementation of staffing plan	
Completed	B. IDN Admin Lead compiles RFPs from IDN Member Entities to fund workforce capacity building activities and initiatives	
Completed	C. IDN Executive Governance Committee approves IDN project budgets for 2017-2020, including recruitment and hiring, retention and sustainability, as well as training strategies	
Completed	D. IDN Career Fair held	
Completed	E. IDN member entities identify workforce targets and training plans in Scope of Work, as part of IDN sub-contracts	
Completed	II. Deployment of training plan	
Completed	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	
Completed	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
Completed	A1a. Training: Dartmouth Hitchcock conducted overview of their social determinants of health tool and pathways process as part of their Substance Use and Mental Illness (SUMHI) initiative to the full IDN on March 19, 2018	8 primary care; 9 behavioral health; 6 care coordinators/case managers were trained
Completed	A1b. Training: Engaging Community Partners in Addressing Social Determinants of Health provided by DHHS/Myers and Stauffer in May 2018	6 primary care; 1 behavioral health; and 1 care coordinators/case managers were trained
Completed	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	
Completed	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
Completed	B1a. Case Western Reserve University conducted training for the IDDT team, as well as others from GNMHC and HEARTS related to the Stages of Change and Treatment as part of the Integrated Dual Diagnosis Treatment (IDDT) workforce training on December 5-6, 2017.	1 primary care; 6 behavioral health; 3 care coordinators/case managers
Completed	B1b. Training: Case Western Reserve University conducted training for the IDNs across the state in as part of the Dual Diagnosis Capability in Addiction Treatment Program in partnership with IDN 4 on January 30-31, 2018.	0 primary care; 3 behavioral health; and 0 care coordinators/case managers were trained
Completed	B1c. Training: Co-occurring disorders (mental health and substance use disorders) provided by NH Healthy Families on June 15, 2018 to Southern NH Health Grand Rounds.	4 primary care; 0 behavioral health; and 0 care coordinators/case managers were trained
Completed	B1d. Training: Co-occurring disorders (mental health and substance use disorders) provided by NH Healthy Families on June 22, 2018 to Full IDN at a monthly meeting.	2 primary care; 2 behavioral health; and 4 care coordinators/case managers were trained
Completed	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	
Completed	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
Completed	C1a. Training: Case management/care coordination for care transitions was conducted as part of the Hunter College Critical Time Intervention (CTI) staff training on November 15-16, 2017 and again on March 19-20, 2018.	0 primary care; 1 behavioral health; and 1 care coordinators/case managers were trained
Completed	C1b. Training: Peer support and recovery coach support training was provided at an IDN monthly meeting on January 25, 2018.	3 primary care; 1 behavioral health; and 4 care coordinators/case managers were trained
Completed	C1c. Training: Case management/NH Wrap-Around Program training was conducted by NH DHHS on April 19, 2018.	1 primary care; 8 behavioral health; and 4 care coordinators/case managers were trained
Completed	C1d. NH Healthy Families' patient portal/data analytics training was conducted at a Full IDN monthly meeting on April 26, 2018.	3 primary care; 5 behavioral health; and 3 care coordinators/case managers were trained
Completed	D. Train IDN provider organizations in cultural competency and adaptation, including unpacking assumptions and stigma across cultures	
Completed	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
Completed	E. Train IDN provider organizations in issues related addiction to increase awareness and understanding of its effect and implications on their work	
Completed	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
Completed	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	
Completed	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	
Completed	F2. Provide training cultural competency and adaptation to up to 262 non-direct care staff across IDN practices/organizations	
Completed	F3. Provide training in addressing challenges with coding to up to 262 non-direct care staff across IDN practices/organizations	
Completed	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	G1. Provide interpersonal communication training to up to 30 case managers and/or BH coordinators/specialists	
Completed	G2. Train case managers and/or BH coordinators/specialists in collaboration and teamwork	
Completed	G3. Provide collaboration and teamwork training to up to 30 case managers and/or BH coordinators/specialists	
Completed	G4. Provide care planning and care coordination training to up to 30 case managers and/or BH coordinators/specialists	

Status	Task Name	Comments
Completed	G5. Provide intervention training to up to 30 case managers and/or BH coordinators/specialists	
Completed	G6. Provide systems-oriented practice training to up to 30 case managers and/or BH coordinators/specialists	
Completed	G7. Provide practice-based learning and quality improvement training to up to 30 case managers and/or BH coordinators/specialists	
Completed	G8. Provide informatics training to up to 30 case managers and/or BH coordinators/specialists	
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	A1. Engage individuals in providing email feedback on revised STCs on CCSA, as well as policies and workflows for IDN 3 CCSA	
Completed	B. Develop IDN 3 CCSA tool with CCSA and Referrals Work Team	
Completed	B1. CCSA Work Team builds upon SDOH domain questions from DH screening tool from its pilot	
Completed	B2. CCSA Work Team hosts DH learning session with IDN to learn more about their screening process and lessons learned	
Completed	B3. CCSA Work Team garners input from IDN provider organizations (Advisory Committee) to make recommendations to Clinical Governance Committee	
Completed	B4. Clinical Governance Committee votes on recommendations	
In Progress	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	
Completed	C1. Request information on tools, protocols and workflows from all IDN Member Entity provider partners who would conduct screens in an office visit	
Completed	C1a. Compile responses and share with IDN Advisory Committee in preparation for sharing recommendations to Clinical Governance Committee at April 2018 Quarterly Governance meeting	
Completed	C2. Develop workflows and protocols for referrals based upon positive screening results	
Completed	C3a. In collaboration with CCSA and Referrals Work Team to identify referral sources for positive screens on CCSA domains	
Completed	C3. Finalize IDN acceptable CCSA completion, positive screens and intervention/referral protocols/workflows	
Completed	C3a. Share draft CCSA, final STCs, provider screening tools/workflows/protocols, and recommendations to Advisory Committee	
Completed	C3b. Share recommendations with Clinical Governance Committee for their vote	
Completed	C3c. Clinical Governance Committee votes on CCSA policies, protocols and workflows for IDN providers	
In Progress	D. Engage IDN provider practices/organizations in identifying next steps for operationalizing workflows for use of CCSA	
Completed	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)	
Completed	Review potential of utilizing PatientLink platform as database for CCSA with IT/Data Committee and Clinical Committee, if organization does not build into EHR, learning from IDN 4's potential use of platform	The IT/Data Committee has recommended not utilizing PatientLink for CCSA implementation at this time. Our partners are either incorporating the CCSA into their EHR systems or using the paper version
Completed	Engage in vendor demo with use of draft IDN 3 CCSA tool	
Completed	IT/Data Committee makes recommendation to Clinical Committee	Recommendation is not to use PatientLink at this time
Not Applicable	Clinical Committee votes and makes recommendation to Finance Committee	expected to occur via e-vote
Not Applicable	Finance Committee votes and makes recommendation to Executive Committee	expected to occur via e-vote
Not Applicable	Executive Committee votes on use of PatientLink platform for CCSA for non-EHR provider organizations	expected to occur via e-vote
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	A1. Invite IDN members, with the goal of broad representation to review STCs, to identify existing use of care plans across providers, and determine recommendations for workflows and protocols to Clinical Governance Committee	through use of approved protocols and content from statewide SCP Taskforce
In Progress	A2. Conduct regular meeting of work team in months between quarterly Clinical Governance Committee meetings	
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	
In Progress	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	D1a. Develop IDN protocol policy recommendations for case managers/care coordinators to integrate patient follow-up plan/interventions from CCSA (either in EHR, PatientLink, or other care management system) into SCP in CMT platform	to be piloted with target sub-population within each provider organization - Multi-Disciplinary Case Management Guidelines (MDCM) will cover this subject
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 CMT ADT to emergency departments flags at SNHMC and St. Joseph Hospital	
In Progress	E1. SCP and Case Management Work Team reviews CMT template guidance in collaboration with TA from CMT on best practices	
In Progress	E2. SCP and Case Management Work Team develops recommended care guidelines protocols for inclusion in PreManage ED notifications for IDN attributed Medicaid patients	
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	
Completed	A1. Initiate Critical Time Intervention (CTI) multi-disciplinary core team structure/processes	complete
Completed	A2. Initiate IDDT multi-disciplinary core team structure/processes	complete
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	B1. Pilot SCP workflows and protocols with CTI and IDDT clients to start	
In Progress	B2. Engage current greater Nashua area wrap-around and community care teams to identify opportunities for overlapping goals	

Status	Task Name	Comments
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	
Completed	A1. The Youth Council, through their funding allocations in the A1 and D3 project budgets, pilots documented workflows for Project IMPACT (Integrated Middle School Project Providing Assessment and Collaboration Together) for youth in the Nashua Middle Schools	
Completed	A1a. Workflow and protocols for referral tool developed and piloted via paper and phone/fax until HIT platforms are in place	
Completed	A1b. Workflow and tool for youth informed consent is developed and piloted	
Completed	A1c. Workflow and tool for parental informed consent is developed and piloted	
Completed	A1d. Workflow is developed and piloted for use of the Screening to Brief Intervention (S2BI) tool for substance use screening, as well as the Project IMPACT Questionnaire tool, which incorporates questions from the Patient Health Questionnaire (PHQ)	
Completed	A1e. Workflow developed and piloted for use of the contact notes form for interactions with parents, providers, and other members of the care team for Project IMPACT participants	
In Progress	A2. Greater Nashua Mental Health Center (GNMHC), through their funding allocation in the C1 project budget, pilots documented workflows for the Critical Time Intervention (CTI) program	
Completed	A2a. Workflow and protocols for eligibility screening and referral developed and piloted (via paper and phone/fax until HIT platforms are in place)	
Completed	NH Hospital	
Completed	Southern NH Medical Center	
No Progress	St. Joseph Hospital	
Completed	A2b. Workflow and tool for patient consent developed and piloted in EHR	
Completed	A2c. Workflow developed and piloted for use of the Adult Needs and Strengths Assessment (ANSA) tool to support creation of the case management care plan in EHR, to have incorporated into CMT shared care plan when in place	
Completed	A2d. Workflow developed and piloted for use of the patient progress tracking in organizational EHR and when available, in shared care plan, as appropriate for information sharing with IDN treatment and social support services provider partners	
Completed	A3. Greater Nashua Mental Health Center (GNMHC), through their funding allocation in the E4 project budget, pilots documented workflows for the Integrated Dual Diagnosis Treatment (IDDT) program	
In Progress	B. Engage Collective Medical Technologies (CMT) 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 CMT to support PreManage ED and PreManage Primary on behalf of IDN providers	
In Progress	B2. Engage IDN hospitals in contracting with CMT and participating in meetings and calls with CMT's project management staff to implement the PreManage ED platform to receive and submit ADTs for the IDN attributed Medicaid population	
Completed	B2a. SNHMC	SNHMC went live with CMT Pre-Managed ED on 09/18/18
Completed	Complete Master Services Agreement and BAA are completed with CMT	
Completed	SNHMC ED Director and their team identifies criteria for triggers in ED for IDN attributed patients	
Completed	Complete VPN and interface process with CMT to connect with EHR	
Completed	Data Analyst creates historical file extract for encounters in emergency department, inpatient department, observation, and immediate care locations	
In Progress	ADT feeds begin for criteria set by ED Director and their team	expected by August 2018
In Progress	B2b. St. Joseph Hospital and Physician Practices	
In Progress	Complete Master Services Agreement and BAA are completed with CMT	
In Progress	St. Joseph Hospital Director and team identifies criteria for triggers in ED for IDN attributed patients	
In Progress	Complete VPN and interface process with CMT to connect with EHR	
In Progress	Data Analyst creates historical file extract for encounters in emergency and inpatient department admissions, discharges and transfers	
In Progress	ADT feeds begin for criteria set by ED Director and their team	
In Progress	C2c. Engage IDN provider organizations and practices in contracting with CMT and participating in meetings and calls with CMT's project management staff to implement the PreManage Primary 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	C2ci. Meeting with Foundation Medical Partners to begin to determine triggers, roles and workflows for use of CMT platform, including event notifications and engagement in shared care plan	
In Progress	C3. Engage Kno2 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	
In Progress	C3a. Each IDN member entity completes credentialing and contracting process with Kno2	
In Progress	C3b. Each IDN member entity incorporates use of Kno2 into its workflow for sharing PHI across IDN providers	
Completed	Stage 1: Outcome Metrics (Initiation of Data Reporting) July to December 2017	
Completed	I. Report on the number of Medicaid beneficiaries who received Comprehensive Core Standardized Assessment (during reporting period and cumulative) vs. projected	
Completed	A1. 0 completed vs. 0 projected	expected in next reporting period
Completed	II. Report on the number of Medicaid beneficiaries scoring positive on scoring tools	
Completed	A1. 0 positive vs. 0 projected	expected in next reporting period
Completed	III. Report on the number of Medicaid beneficiaries scoring positive on scoring tools and referred for additional intervention	
Completed	A1. 0 with positive and interventions vs. 0 projected	expected in next reporting period
Completed	IV. Report on the number of new staff positions recruited and trained (during reporting period and cumulative) vs. projected	
Completed	A.	
Completed	A2.	
Completed	V. Report on the impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	
Completed	A1. Report on impact measures identified in IDN evaluation plan during reporting period	
Completed	A2. Report on baseline fidelity assessment for evidence-supported strategies	
Completed	Stage 2: Outcome Metrics (Ongoing Data Reporting) January to June 2018	
Completed	I. Report on the number of Medicaid beneficiaries received Comprehensive Core Standardized Assessment (during reporting period and cumulative) vs. projected	
Completed	A1. 0 completed vs. 0 projected	expected in next reporting period
Completed	II. Report on the number of Medicaid beneficiaries scoring positive on scoring tools	

Status	Task Name	Comments
Completed	A1. 0 positive vs. 0 projected	expected in next reporting period
Completed	III. Report on the number of Medicaid beneficiaries scoring positive on scoring tools and referred for additional intervention	
Completed	A1. 0 with positive and interventions vs. 0 projected	expected in next reporting period
Completed	IV. Report on the number of new staff recruited and trained (during reporting period and cumulative) vs. projected	
Completed	A. 6.5 recruited vs. 19 projected	
Completed	B. # trained vs. projected	
Completed	B1. Universal screening/use of screening tools: 14 primary care vs. 206 projected; 9 behavioral health vs. 75 projected; 6 care coordinators/case managers vs. 126	
Completed	B2. Co-occurring disorders: 7 primary care vs. 213; 11 behavioral health vs. 73; and 7 care coordinators/case managers vs. 125	
Completed	B3. Care planning and care coordination models and best practices: 7 primary care vs. 213; 15 behavioral health vs. 69; 12 care coordinators/case managers vs. 120	
Completed	B4. Cultural competency and adaptation: 41 primary care vs. 179; 21 behavioral health vs. 63; 32 care coordinators/case managers vs. 100	
Completed	B5. Understanding of addiction: 5 primary care vs. 215; 21 behavioral health vs. 63; 20 care coordinators/case managers vs. 112	
Completed	V. Report on the new staff vacancy and turnover rate for period and cumulative vs. projected	
Completed	A. 0 turnover vs. projected	
Completed	VI. Report on the impact measures as defined in evaluation plan	
	<b>Outcome Metrics (Stage 3 System Transformation Utilization Milestones): Ongoing Data Reporting (July - December 2018)</b>	
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	

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
<b>Dartmouth Hitchcock (DH) Practices</b>													
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
<b>Foundation Medical Partners (FMP) Practices</b>													
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
Healthy at Home	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	IP	N/A	N/A
Keystone Hall	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	IP	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	IP	IP	Y	IP	Y	Y	Y	N/A	N/A
<b>St. Joseph Hospital and Physician Practices (SJH)</b>													
SJH Nashua Family Medicine	Y	Y	Y	Y	IP	Y	IP	Y	Y	Y	IP	Y	Y
SJH Nashua Internal Medicine	Y	Y	Y	Y	IP	Y	IP	Y	Y	Y	IP	Y	Y
SJH Nashua Pediatrics	Y	Y	Y	Y	IP	Y	IP	Y	Y	Y	IP	Y	Y
SJH Hudson	Y	Y	Y	Y	IP	Y	IP	Y	Y	Y	IP	Y	Y
SJH Milford	Y	Y	Y	Y	IP	Y	IP	Y	Y	Y	IP	Y	Y
SJH Merrimack	Y	Y	Y	Y	IP	Y	IP	Y	Y	Y	IP	Y	Y
SJH Adult Medicine	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP	IP
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

**Greater Nashua Integrated Delivery Network (IDN)  
Comprehensive Core Standardized Assessment (CCSA)  
Ages 12 and Older**

Health starts long before illness - in our homes, schools, and jobs. The more we know about you, the better health care we can provide. Responses below will always be kept private and confidential among the providers on your care team.

**About You**

First Name, Middle Name, Last Name:	Date of Birth (dd/mm/yyyy): ____/____/____
Today's Date: ____/____/____	Initials of Reviewer

**Health and Wellness (Select one choice per question)**

	Yes	No
Do you see your doctor at least once a year for a physical or well care visit?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an emergency room (ED) visit in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently or have you ever smoked cigarettes or used any other smokeless tobacco products? (E.g. chewing tobacco, snuffs, dissolvable, vapor cigarettes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

**Substance Use (Select one choice per question)**

	Never	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How many times in the past year have you used an illegal drug or used a prescription medication not as prescribed?	<input type="checkbox"/>					

	Never	Less than monthly	Monthly	Weekly	Daily/almost daily
How often do you have a drink containing alcohol?	<input type="checkbox"/>				
How often have you had 5 or more drinks containing alcohol in a day?	<input type="checkbox"/>				

**Mental Health (Select one choice per question)**

Over the <i>last 2 weeks</i> , 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead, or of hurting yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Social Needs and Connections (Select one choice per question unless otherwise noted)**

	Yes	No
Are you worried about losing your housing or are you homeless?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently having issues at home with your utilities such as your heat, electric, natural gas or water?	<input type="checkbox"/>	<input type="checkbox"/>
Do you/your family worry about whether your food will run out and you won't be able to get more?	<input type="checkbox"/>	<input type="checkbox"/>
Has lack of transportation kept you from medical appointments, meetings, work, school or from getting things needed for daily living?	<input type="checkbox"/>	<input type="checkbox"/>
In the past year, have you been afraid of your partner or ex-partner?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel physically and emotionally safe where you currently live?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any legal issues that are getting in the way of your health or healthcare or your general well-being?	<input type="checkbox"/>	<input type="checkbox"/>
<p align="center">If yes to legal issues, what areas are most impacted (<b>check all that apply</b>)?</p> <p align="center"> <input type="checkbox"/> Housing    <input type="checkbox"/> Financial    <input type="checkbox"/> Employment    <input type="checkbox"/> Transportation    <input type="checkbox"/> Family    <input type="checkbox"/> Healthcare         </p> <p>Other: _____</p>		

	Less than once a week	1 – 2 times a week	3 – 5 times a week	More than 5 times a week
How often do you see or talk to people that you care about and feel close to? (e.g., talking to friends on the phone, visiting friends or family, going to a faith-based service/group or club meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p align="center">Do you need assistance with any of the following tasks (<b>check all that apply</b>)?</p> <p align="center"> <input type="checkbox"/> Bathing/Showering    <input type="checkbox"/> Toileting    <input type="checkbox"/> Dressing    <input type="checkbox"/> Maintaining Personal Hygiene  <input type="checkbox"/> Taking Your Medications    <input type="checkbox"/> Preparing Meals    <input type="checkbox"/> Feeding Yourself    Other: _____         </p>				

**Education and Employment (Select one choice per question)**

	Yes	No		
Are you currently attending school?	<input type="checkbox"/>	<input type="checkbox"/>		
	Middle school	High school diploma or equivalent	More than high school	
What is the highest level of school you have finished?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Working full-time	Working part-time or in temporary work	Unemployed and seeking work	Unemployed but not seeking work (e.g., student, retired, disabled, unpaid primary caregiver)
What is your current work situation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Greater Nashua Integrated Delivery Network (IDN 3)  
Comprehensive Core Standardized Assessment (CCSA)  
Youth up to 14 years of age**

Health starts long before illness - in our homes, schools, and jobs. The more we know about you, the better health care we can provide. Responses below will always be kept private and confidential among the providers on your care team. Although “your child” is referenced throughout, your relationship may be other than a parent or caretaker. Please take a minute to describe your relationship below.

First Name, Middle Name, Last Name of Patient		Patient Date of Birth (dd/mm/yyyy): ____/____/____
First Name, Middle Name, Last Name of Person Filling Out This Form:		Relationship to Patient
How confident are you filling out forms for your child? <input type="checkbox"/> Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely		
Are You the Legal Parent or Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	Today's Date ____/____/____	Initials of Reviewer (Please leave blank)

**Health and Wellness (Select one choice per question unless otherwise noted)**

	Yes	No	
Does your child see his/her doctor at least once a year for a physical or well care visit?	<input type="checkbox"/>	<input type="checkbox"/>	
Has your child had an emergency room (ED) visit in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child exercise or play sports that make him/her sweat or breathe hard for 30 minutes at least 3 times per week?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	
	Not at All	Somewhat Hard	Very Hard
In the past 12 months, how hard is it for you to pay for your child's medical care and medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns related to your child's development in the following areas: <b>(check all that apply)?</b>			
<input type="checkbox"/> Gross Motor Skills ( <i>larger movements your child makes with his arms, legs, feet, or his entire body</i> ) <input type="checkbox"/> Fine Motor Skills ( <i>smaller actions your child performs using fingers and toes or facial expressions</i> ) <input type="checkbox"/> Communication and speech <input type="checkbox"/> Social Behavior			
Does your child need assistance with any of the following tasks <b>(check all that apply)?</b>			
<input type="checkbox"/> Bathing/Showering <input type="checkbox"/> Toileting <input type="checkbox"/> Dressing <input type="checkbox"/> Maintaining Personal Hygiene <input type="checkbox"/> Taking Their Medications <input type="checkbox"/> Grooming <input type="checkbox"/> Feeding Themselves <input type="checkbox"/> Other: _____			

**Education and Employment (Select one choice per question)**

	Home Schooled	Yes	No	Not Applicable
Is your child enrolled in school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Yes	No	Not Applicable
Does your child hold a job?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Social Needs and Connections (Select one choice per question)**

		Yes	No		
Are you currently having issues at home with your utilities ( <i>heat, electric, natural gas or water</i> )?		<input type="checkbox"/>	<input type="checkbox"/>		
Does you/your family worry about whether your food will run out and you won't be able to get more?		<input type="checkbox"/>	<input type="checkbox"/>		
Do you or your child have any legal issues that are getting in the way of your health or well-being of your child?		<input type="checkbox"/>	<input type="checkbox"/>		
In the past 12 months, has lack of transportation kept you from keeping your child's medical appointments, meetings, or from getting things needed for daily living?		<input type="checkbox"/>	<input type="checkbox"/>		
Does your child feel physically and emotionally safe where you currently live?		<input type="checkbox"/>	<input type="checkbox"/>		
	I have housing	I have housing today but am worried about losing housing in the future		I do not have housing	
What is your housing situation for your child today?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
		Less than once a week	1 – 2 times a week	3 – 5 times a week	5 or more times a week
How often does your child see or talk to people that they care about and feel close to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Hardly Ever	Some of the time	Often
How often does your child appear isolated from others?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Mental Health (Select one choice per question)**

Does your child struggle with any of the following:	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, irritable or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of suicide, feelings that he/she would be better off dead, or have thoughts of harming him/herself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Substance Use (Select one choice per question)**

During the past 12 months, did your child:	Yes	No
Drink any alcohol (more than a few sips)? (Do not count sips or alcohol taken during family or religious events)	<input type="checkbox"/>	<input type="checkbox"/>
Smoke any marijuana or hashish?	<input type="checkbox"/>	<input type="checkbox"/>
Use anything else to get high? (includes illegal drugs, over the counter and prescription drugs, and anything that can be "sniffed" or "huffed", etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Use any tobacco products? (includes cigarettes, chewing tobacco, snuffs, dissolvable, vapor cigarettes, any smokeless tobacco products, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

# IDN-3 Assess Measure Narrative

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DECISION MAKING PROTOCOLS & GUIDELINES

V1.4



Delivery System Reform Incentive Payment (DSRIP)  
Integrated Delivery Network (IDN) 3

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## Change Log

Date	Change	Version
07/03/18	Document Created; Measures included: <ul style="list-style-type: none"> <li>• ASSESS_SCREEN.01</li> <li>• ASSESS_SCREEN.02 - sub-Measures:               <ul style="list-style-type: none"> <li>○ ASSESS_SCREEN.02-A</li> <li>○ ASSESS_SCREEN.02-B</li> </ul> </li> <li>• ASSESS_SCREEN.03 - sub-Measures:               <ul style="list-style-type: none"> <li>○ ASSESS_SCREEN.03_Sub_A</li> <li>○ ASSESS_SCREEN.03_Sub_B</li> <li>○ ASSESS_SCREEN.03_Sub_C</li> <li>○ ASSESS_SCREEN.03_Sub_D</li> <li>○ ASSESS_SCREEN.03_Sub_E</li> <li>○ ASSESS_SCREEN.03_Sub_F</li> </ul> </li> <li>• ASSESS_SCREEN.04</li> </ul>	V1.0
08/07/18	Updated what constitutes CCSA completion and added notes for ASSESS_SCREEN.01 table under "What is considered a <b>"complete" CCSA</b> by the IDN?" section; updated ASSESS_SCREEN.01 flow to reflect completion criteria change.	V1.1
08/22/18	Added measures: <ul style="list-style-type: none"> <li>• CARE.03 - sub-Measures:               <ul style="list-style-type: none"> <li>○ CARE.03_Sub_A</li> <li>○ CARE.03_Sub_B</li> </ul> </li> <li>• HOSP_INP.02</li> </ul>	V1.2
08/24/18	Reorganized document to changed focus on those measures which still require clinical review and approval: <ol style="list-style-type: none"> <li>1. ASSESS_SCREEN.03:               <ol style="list-style-type: none"> <li>a. ASSESS_SCREEN.03_Sub_A – Intimate Partner Violence Screening and Applicable Referrals</li> <li>b. ASSESS_SCREEN.03_Sub_B – Blood Pressure Screening</li> <li>c. ASSESS_SCREEN.03_Sub_C – Adult Lipid Screening</li> <li>d. ASSESS_SCREEN.03_Sub_D – Adolescent Tobacco Use Interventions</li> <li>e. ASSESS_SCREEN.03_Sub_E – Adult Obesity Screening and Counseling</li> <li>f. ASSESS_SCREEN.03_Sub_F – Child Obesity and Overweight Screening and Counseling</li> </ol> </li> <li>2. CARE.03:               <ol style="list-style-type: none"> <li>a. CARE.03_Sub_A – Controlling High Blood Pressure</li> <li>b. CARE.03_Sub_C – Comprehensive Diabetes Care - HbA1c Control &lt;8.0%</li> </ol> </li> </ol> Those measures already reviewed and approved have been moved to the end of the document for reference.	V1.2
09/19/18	Updates based on Clinical Advisory Committee e-review comments conducted 09/06/18	V1.3
09/24/18	Added HOSP_INP.02 for Clinical Governance Committee Approval	V1.3
10/08/18	Document Approved by Clinical Governance Committee via E-vote	V1.3
10/15/18	Updated and reorganized document to include all approved polices & guidelines	V1.4

## Glossary

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**Activities of Daily Living and Instrumental Activities of Daily Living (ADL and IADL)** – Activities of Daily Living (ADLs) are basic self-care tasks, such as feeding, toileting, selecting proper attire, grooming, maintaining continence, putting on clothes, bathing, walking and transferring (such as moving from bed to wheelchair). Instrumental Activities of Daily Living (IADLs) are more complex skills needed to successfully live independently such as managing finances, preparing meals, managing medications, ability to drive, etc.

**Assessment Measures (Assess\_Screen.x)** – Clinical outcome measures are used by the NH DSRIP (Delivery System Reform Incentive Payment) program to evaluate Integrated Delivery Network (IDN) performance for incentive payment. These measures are part of CMS approved protocols (and hence the IDN contracts) and also allow the Department (NH Department of Health and Human Services) to support DSRIP oversight and evaluate overall program impact.

**Attributed Population** – Every NH Medicaid beneficiary is attributable to one (and only one) IDN for the basis of the DSRIP demonstration funding formula and for the measurement of performance metrics for each IDN. The principle of the attribution methodology is that beneficiaries should be attributed to IDNs based upon where they currently receive their care, however, that is not always possible to identify, so attribution is based upon four factors: 1) use of long-term care facility providers, 2) use of mental health/substance use disorder providers (including Community Mental Health Center) providers, 3) use of primary care providers, 4) geographic criteria (when necessary).

**Attributed Behavioral Health Population** - DHHS determined subset of the Medicaid population that is broadly likely using, at risk for, or in need of behavioral health care. Because IDN's do not have all the data needed to determine whether a patient is included in the behavioral health population for this measure, DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee five months after the end of each measure data source time period. The IDN will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for this measure

**Behavioral Health Population** – DHHS determined subset of the Medicaid population that is broadly likely using, at risk for, or in need of behavioral health care.

**Behavioral Health** – Behavioral health includes mental health services as well as Substance Use Disorder (SUD) services.

**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. The assessment is intended to be a standardized screening process that integrates medical, behavioral and social needs and results in the identification of needs with appropriate referrals and linkages. Standardization results from the screening of a core set of domain areas. The IDN is required to develop and implement CCSA protocols that detail the requirements for the assessment process, documentation, expectations of providers and training plan, tools used, and referral process for assessment findings and individual needs.

**DHHS** – Department of Health and Human Services.

**DSRIP** - Delivery System Reform Incentive Payment is a vehicle for states to improve health outcomes and population health by reforming the health care delivery system to be more effective in addressing both physical and behavior health for the Medicaid population.

**DSRIP Measure Narrative & Detailed Specification Guide (DSRIP Measures)** – This guide, created by DHHS provides detailed definitions for each outcome measure used by the NH DSRIP program to evaluate IDN performance for improvement and incentive payment. This document (along with the DHHS STC's) is the basis for IDN-3's recommended policies and procedures to support its member entities as they deliver data to the Quality Reporting Service (QRS), the Massachusetts e-Health Collaborative (MAeHC) as it reports to DHHS on the IDN's behalf., and is referenced throughout this document as DSRIP Measures.

**Electronic health record (EHR) or other electronic tracking system** – For the purposes of this document, an Electronic Health Record or other electronic tracking system, includes a treatment provider's medical record system (e.g., Epic, GE Centricity), a platform that allows IDN member entities to store or query data, or the IDN's reporting service, MAeHC.

**Integrated Delivery Network (IDN)** - The provider networks that form regional coalitions and collectively pool funds as a single region, based upon attributed population.

**IDN's Medicaid Billing Provider** – A provider who accepts NH Medicaid as part of the IDN.

**Medicaid Population** – For the purpose of DSRIP demonstration, the Medicaid population includes those NH residents enrolled in a Medicaid Managed Organization (NH Healthy Families or WellSense), a Qualified Health Plan as part of NH's premium assistance program (Ambetter commercial plan with PAP indicator, Anthem commercial plan with PAP in group name, Harvard Pilgrim commercial plan with PAP in group name, or Minuteman commercial plan with PAP in group name, which is plan sunsetting 12/31/17) or a Medicaid Fee for Service (FFS) plan, regardless of whether the person also has coverage from another source (e.g., Medicare, commercial insurance).

**Measurement Attributes** – Each assess measure has the following attributes

- **Numerator** - the number of patients in the denominator who qualify based on the requirements for that specific assessment;
- **Denominator** - the number of patients seen during the period;
- **Percentage** – percentage of patients with current assessments ((numerator / denominator) \*100);

**Office and Community Based Visit** – Preventive, medical or behavioral health encounter at the following locations: school, homeless shelter, office, home, assisted living facility, group home, mobile unit, temporary lodging, walk-in retail clinic, place of employment, independent clinic, federally qualified health center, mental health center, non-residential substance abuse treatment facility, comprehensive outpatient rehabilitation facility, public health clinic, and rural health clinic.

**Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)** - In 2013, the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, the Oregon Primary Care Association, and the Institute for Alternative Futures collaborated to develop PRAPARE, a national effort to help health centers and other providers collect the data needed to better understand and act on their patients’ social determinants of health. It aligns with national initiatives prioritizing social determinants (e.g., Healthy People 2020), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10, and health centers’ Uniform Data System (UDS) and PREPARE templates are available for most EHR systems.

**Social Determinants of Health (SDOH)** - income, educational attainment, employment status, and access to food and housing

**Special Terms and Conditions (STC’s)** - Special Terms and Conditions enable the State of NH (and the IDNs) to operate the demonstration, setting forth the nature, character, and extent of federal involvement in the demonstration and are approved through December 31, 2020

**USPSTF** – U.S. Preventive Services Task Force is an independent panel (appointed by a federal agency) of national experts in disease prevention and evidence-based medicine that works to improve the health of the population by making evidence-based recommendations about clinical preventive service.

**Well Care Visit** – Comprehensive preventive medicine evaluation and management visits that may or may not include evaluation and management of specific conditions.

## Introduction

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New Hampshire's *Building Capacity for Transformation* Section 1115 demonstration aims to transform the way care is delivered to some of the most medically complex and costly Medicaid beneficiaries in the state as well as to children, youth and adults with undiagnosed or untreated behavioral health conditions. This will be accomplished through transforming the behavioral health delivery system through:

- Integrating physical and behavioral health to better address the full range of beneficiaries' needs;
- Expanding provider capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

Through the New Hampshire Building Capacity for Transformation section 1115(a) Medicaid Special Terms and Conditions, the state is able to provide performance based funding to regionally-based Integrated Delivery Networks (IDNs) who furnish Medicaid services to demonstrate new programs and policies to address the above issues by partnering Primary care providers, behavioral health providers, and social services organizations to implement an integrated care model.

Clinical outcome measures are used by the NH DSRIP (Delivery System Reform Incentive Payment) program to evaluate Integrated Delivery Network (IDN) performance for incentive payment. These measures are part of CMS approved protocols (and hence the IDN contracts) and also allow the Department (NH Department of Health and Human Services) to support DSRIP oversight and evaluate overall program impact. The outcome measures are defined in DSRIP Program Outcome Measures Guide provided by DHHS. This document will be updated as needed based on revisions received from DHHS for the DSRIP Program Outcome Measures Guide.

The purpose of this document is to evaluate those requirements and provide the recommended guidelines and policies specifically for IDN-3 member entity providers responsible for providing data to support the outcomes. While there are more than 30 outcome measures, the IDN is responsible for providing data related to a few of them directly and will do that through contracting with the Massachusetts eHealth Collaborative (MAeHC), the IDN's Quality Reporting Service (QRS).

This document provides IDN guidelines and policies related to those outcomes MAeHC will validate and report against to DHHS:

1. ASSESS\_SCREEN.01 - Use of Comprehensive Core Standardized Assessment Process by IDN Primary Care, BH and SUD Providers
2. ASSESS\_SCREEN.02 - Appropriate Follow-Up for Positive Screenings for Potential Substance Use Disorder and/or Depression by IDN Primary Care and BH Providers Sub-Measures:
  - a. ASSESS\_SCREEN.02-A: Depression
  - b. ASSESS\_SCREEN.02-B: Substance Use Disorder
3. ASSESS\_SCREEN.03 – Selected US Preventive Services Task Force Services for Behavioral Health Population Sub-Measures:
  - a. ASSESS\_SCREEN.03\_Sub\_A – Intimate Partner Violence Screening and Applicable Referrals
  - b. ASSESS\_SCREEN.03\_Sub\_B – Blood Pressure Screening
  - c. ASSESS\_SCREEN.03\_Sub\_C – Adult Lipid Screening
  - d. ASSESS\_SCREEN.03\_Sub\_D – Adolescent Tobacco Use Interventions
  - e. ASSESS\_SCREEN.03\_Sub\_E – Adult Obesity Screening and Counseling
  - f. ASSESS\_SCREEN.03\_Sub\_F – Child Obesity and Overweight Screening and Counseling
4. ASSESS\_SCREEN.04 – Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by the IDN’s Medicaid Billing Providers
5. CARE.03 - Physical Health-Focused Measures for Behavioral Health Population Sub-Measures:
  - a. CARE.03\_Sub\_A – Controlling High Blood Pressure
  - b. CARE.03\_Sub\_C – Comprehensive Diabetes Care - HbA1c Control <8.0%
1. HOSP\_INP.02 - Timely Transmission of Transitional Record After Hospital Discharge

## **The Comprehensive Core Standard Assessment (CCSA)**

Use of a Comprehensive Core Standard Assessment process (conducted at a minimum annually) is the basis for an individualized care plan used by the care team to guide the treatment and management of the target sub-population (IDN attributed Medicaid beneficiaries). The CCSA is intended to be a standardized screening process that integrates medical, behavioral and social needs and results in the identification of needs with appropriate referrals and linkages. Standardization results from the screening of a core set of domain areas. These domains include the following:

1. Demographic
2. Medical
3. Education
4. Employment and Entitlement
5. Housing
6. Functional status (activities of daily living, instrumental activities of daily living, cognitive functioning including transportation)
7. Family and Support Services
8. Legal
9. Depression screening
10. Substance Use (including Tobacco Use)
11. Risk assessment (including Suicide Risk and Intimate Partner Violence)
12. Pediatric developmental screening

The IDN is required to develop and implement CCSA protocols that detail the requirements for the assessment process, documentation, expectations of providers and training plan, tools used, and referral process for assessment findings and individual needs. Where the CCSA process results in the identification of individual needs, the IDN must document the needs and establish referrals that are included in the Care Plan that is shared among core team members and used by the care team to guide treatment. The goal of DHHS is that at any time an individual patient in the attributed Medicaid population is seen at a primary care and behavioral health care visit, the risks associated with the domain areas are assessed according to the IDN CCSA protocols, to the extent possible.

*For complete reference to the IDN 3 CCSA, associated pathways for each domain/question and the closed loop referral process, please refer to the IDN 3 Closed Loop Integrated Health Guidelines document.*

The IDN-3 Clinical Governance Committee approved the IDN Comprehensive Core Standardized Assessment (CCSA) tool to address each domain defined in the DHHS Special Terms and Conditions (STCs). Below is the crosswalk of IDN 3 CCSA tool to each domain:

**1. DEMOGRAPHICS**

Capturing patient name and date of birth (DOB). It was decided at Clinical Committee meeting that other demographics such as age, gender, race, ethnicity, are already being captured as part of provider intake forms or within EHR systems as an existing patient, thus would be duplication if also captured as part of the CCSA tool.

**2. MEDICAL**

<b>Question Origin:</b> PRAPARE tool (slightly modified question)	Yes	No
Do you see your doctor at least once a year for a physical or well care visit?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> DHHS Feedback – intent is to start conversation on use of ED	Yes	No
Have you had an emergency room (ED) visit in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>

**3. EDUCATION**

<b>Question Origin:</b> DHHS Feedback – intent is to start conversation about education, especially for those who are school age & not attending school	Yes	No	
Are you currently attending school?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Question Origin:</b> PRAPARE tool (slightly modified answer choices)	Middle school	High school diploma or equivalent	More than high school
What is the highest level of school you have finished?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### 4. EMPLOYMENT AND ENTITLEMENT

<b>Question Origin:</b> <i>PRAPARE tool (slightly modified answer choices)</i>	Working full-time	Working part-time or in temporary work	Unemployed and seeking work	Unemployed but not seeking work (e.g., student, retired, disabled, unpaid primary caregiver)	
What is your current work situation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Question Origin:</b> <i>PRAPARE tool (slightly modified question/answer choices)</i>					
				Yes	No
Do you have health insurance?				<input type="checkbox"/>	<input type="checkbox"/>

#### 5. HOUSING

<b>Question Origin:</b> <i>PRAPARE tool (slightly modified question – added homelessness inquiry)</i>	Yes	No
Are you worried about losing your housing or are you homeless?	<input type="checkbox"/>	<input type="checkbox"/>

#### 6. FUNCTIONAL STATUS and (INSTRUMENTAL) ACTIVITIES OF DAILY LIVING (ADL/IADL)

<b>Question Origin:</b> <i>PRAPARE tool (slightly modified question to ask specifically about utilities)</i>	Yes	No
Are you currently having issues at home with your utilities such as your heat, electric, natural gas or water?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> <i>PRAPARE tool (slightly modified question to ask specifically about food)</i>	Yes	No
Do you/your family worry about whether your food will run out and you won't be able to get more?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> <i>PRAPARE tool (slightly modified question to be Y/N and added school)</i>	Yes	No
Has lack of transportation kept you from medical appointments, meetings, work, school or from getting things needed for daily living?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> <i>DSM-5 Level 1 tool (slightly modified question)– impact on ADLs/IADLs</i>	Yes	No
Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> <i>Subset list of ADLs/IADLs</i>		
Do you need assistance with any of the following tasks ( <b>check all that apply</b> )?		
<input type="checkbox"/> Bathing/Showering <input type="checkbox"/> Toileting <input type="checkbox"/> Dressing <input type="checkbox"/> Maintaining Personal Hygiene <input type="checkbox"/> Taking Your Medications <input type="checkbox"/> Preparing Meals <input type="checkbox"/> Feeding Yourself            Other: _____		

7. FAMILY & SUPPORT SERVICES

<b>Question Origin:</b> PRAPARE tool	Less than once a week	1 – 2 times a week	3 – 5 times a week	5 or more times a week
How often do you see or talk to people that you care about and feel close to? (e.g., talking to friends on the phone, visiting friends or family, going to a faith-based service/group or club meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. LEGAL

<b>Question Origin:</b> Social Determinants of Health (SDOH)	Yes	No
Do you have any legal issues that are getting in the way of your health or healthcare or your general well-being?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> Social Determinants of Health (SDOH)		
If yes to legal issues, what areas are most impacted ( <b>check all that apply</b> )?		
<input type="checkbox"/> Housing <input type="checkbox"/> Financial <input type="checkbox"/> Employment <input type="checkbox"/> Transportation <input type="checkbox"/> Family <input type="checkbox"/> Healthcare		
Other: _____		

9. DEPRESSION SCREENING

<b>Question Origin:</b> PHQ2				
Over the <i>last 2 weeks</i> , 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. SUBSTANCE USE (including Tobacco Use) – based on SBIRT model

<b>Question Origin:</b> DSM-5 Level 1 tool (slightly modified question)						Yes	No
Do you currently or have you ever smoked cigarettes or used any other smokeless tobacco products? (E.g. chewing tobacco, snuffs, dissolvable, vapor cigarettes, etc.)						<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> DSM-5 Level 1 tool (slightly modified question)		Never	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How many times in the past year have you used an illegal drug or used a prescription medication not as prescribed?		<input type="checkbox"/>					
<b>Question Origin:</b> : AUDIT tool (slightly modified answer choices)		Never	Less than monthly	Monthly	Weekly	Daily/ almost daily	
How often do you have a drink containing alcohol?		<input type="checkbox"/>					
<b>Question Origin:</b> AUDIT tool		Never	Less than monthly	Monthly	Weekly	Daily/ almost daily	
How often have you had 5 or more drinks containing alcohol in a day?		<input type="checkbox"/>					

11. RISK ASSESSMENT (including Suicide Risk and Intimate Partner Violence)

<b>Question Origin:</b> PRAPARE tool					Yes	No
In the past year, have you been afraid of your partner or ex-partner?					<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> PRAPARE tool					Yes	No
Do you feel physically and emotionally safe where you currently live?					<input type="checkbox"/>	<input type="checkbox"/>
<b>Question Origin:</b> PHQ-9						
Over the <i>last 2 weeks</i> , how often have you been bothered by:		Not at all (0)	Several Day (1)	More than half the days (2)	Nearly every day (3)	
Thoughts that you would be better off dead, or of hurting yourself?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

12. CHILDREN ONLY: Development and behavioral screening

Lastly, there is a pediatric domain to screen pediatric development using age appropriate standardized and validated tools. These will be addressed separately.

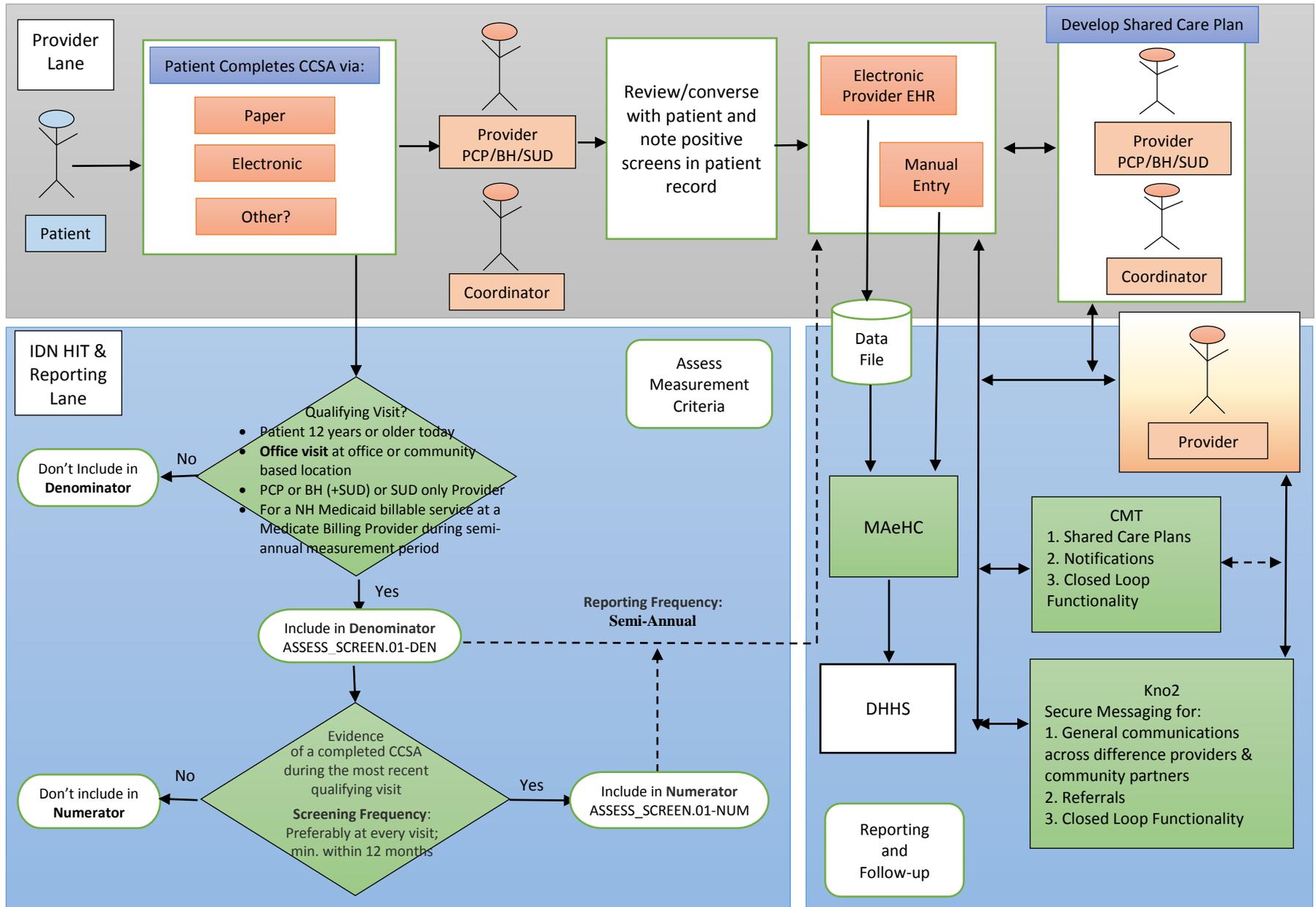
## ASSESS\_SCREEN.01 - Use of Comprehensive Core Standardized Assessment Policy and Protocol Considerations

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>Which IDN treatment providers are required to ensure the <b>CCSA</b> is completed by Medicaid patients in office or community based settings and how often?</p>	<p>Required IDN Member Entities (ALL of the below):</p> <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul> <p>Recommended frequency:</p> <ul style="list-style-type: none"> <li>• Minimally: Once every 12 months</li> <li>• Preferred: Every office visit*</li> </ul>		
<p>What is considered a "<b>complete</b>" <b>CCSA</b> by the IDN?</p>	<p>Recommended policy (Select ONE of the below):</p> <ul style="list-style-type: none"> <li>• Yes = patient/client completed* and reviewed a CCSA with a primary care, mental health or substance use disorder treatment provider at the current office visit or within a 12 month period of the current visit and positive screens are discussed and noted in the client's record at the time of the visit</li> <li>• No = patient/client did NOT complete CCSA within a 12 month period of a visit with a primary care, mental health or substance use disorder treatment provider</li> <li>• No = provider (or their designee) did NOT review CCSA with positive responses noted in the client's record at the time of an office visit</li> <li>• Refused = patient/client refused to complete</li> </ul> <p><b>*The CCSA will be considered complete when all domains have been screened within a 30-day period by a single provider organization or at the same provider location when conducted by multi agency, co-located providers. Patient/client can do the CCSA via self or through verbal dialogue/interview with the provider.</b></p>	<p>Eligibility:</p> <ul style="list-style-type: none"> <li>• Patients 12 years old and older and enrolled in Medicaid* at the time of the visit.</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the six month measurement period ("qualifying visit").</li> <li>• Patient has completed the CCSA within 12 months of the most recent qualifying visit.</li> </ul> <p>*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• Patients with only inpatient and/or emergency department hospital visits during the reporting period.</li> </ul>	<p>As per DHHS STCs, the assessment must include all of the following domains: demographic, medical, substance use including tobacco use (SBIRT), housing, family &amp; support services, education, employment and entitlement, legal, risk assessment including suicide risk, functional status.</p> <p>In addition to above, pediatric providers will ensure that all children receive standardized, validated developmental screening, such as the ASQ:3 and/or ASQ SE at 9, 18, and 24/30 month pediatric visits; and use Bright Futures <i>or other</i> American Academy of Pediatrics recognized developmental and behavioral screening system</p> <p>For those patients/clients who need special accommodations to complete the CCSA, the policies and procedures already in place for those patients/clients in their respective practices should be followed (e.g., for those with limited English proficiency can be translated into other languages and/or available to be asked by a provider).</p>

**ASSESS\_SCREEN.01 - Use of Comprehensive Core Standardized Assessment Policy and Protocol Considerations (CONTINUED)**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>What is considered an acceptable <b>CCSA</b> tool by the IDN?</p>	<p>Recommended tools (select ONE of the below):</p> <ul style="list-style-type: none"> <li>• IDN 3 CCSA Tool</li> <li>• Dartmouth Hitchcock Tool</li> <li>• Other CCSA Tool as approved by IDN Clinical Governance Committee that includes all of the required domains (and agreed to by other B1 project partners, as appropriate/applicable)</li> </ul>		<p>Practices where CCSA is piloted will identify their core team to work with the IDN to capture operational workflows and protocols either those already in place or those newly developed in order to implement CCSA as part of an individualized care plan</p> <p>Per DHHS, a documented completed CCSA must be indicated in provider's electronic health record or other electronic tracking system (e.g. MAeHC manual data portal).</p>
<p>How will <b>CCSA</b> information be reported to MAeHC to ensure it is included as a numerator during the reporting period?</p>	<p>Recommended options for capturing and reporting a completed CCSA:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization's EHR <ul style="list-style-type: none"> <li>○ Treatment provider organization to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input measure-related data into MAeHC data portal, indicating provider name and date of CCSA attestation</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of patients seen by the IDN's Medicaid billing providers in the IDN's attributed population who had a completed CCSA:</p> <p><b>ASSESS_SCREEN.01-NUM</b> (Numerator) - # of patients in the denominator with current assessment completed</p> <p><b>ASSESS_SCREEN.01-DEN</b> (Denominator) - # of number of patients seen during the reporting period</p> <p><b>ASSESS_SCREEN.01-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Semi-annually (every 6 months)</li> </ul>	

## ASSESS\_SCREEN.01 - Use of Comprehensive Core Standardized Assessment Component Flow

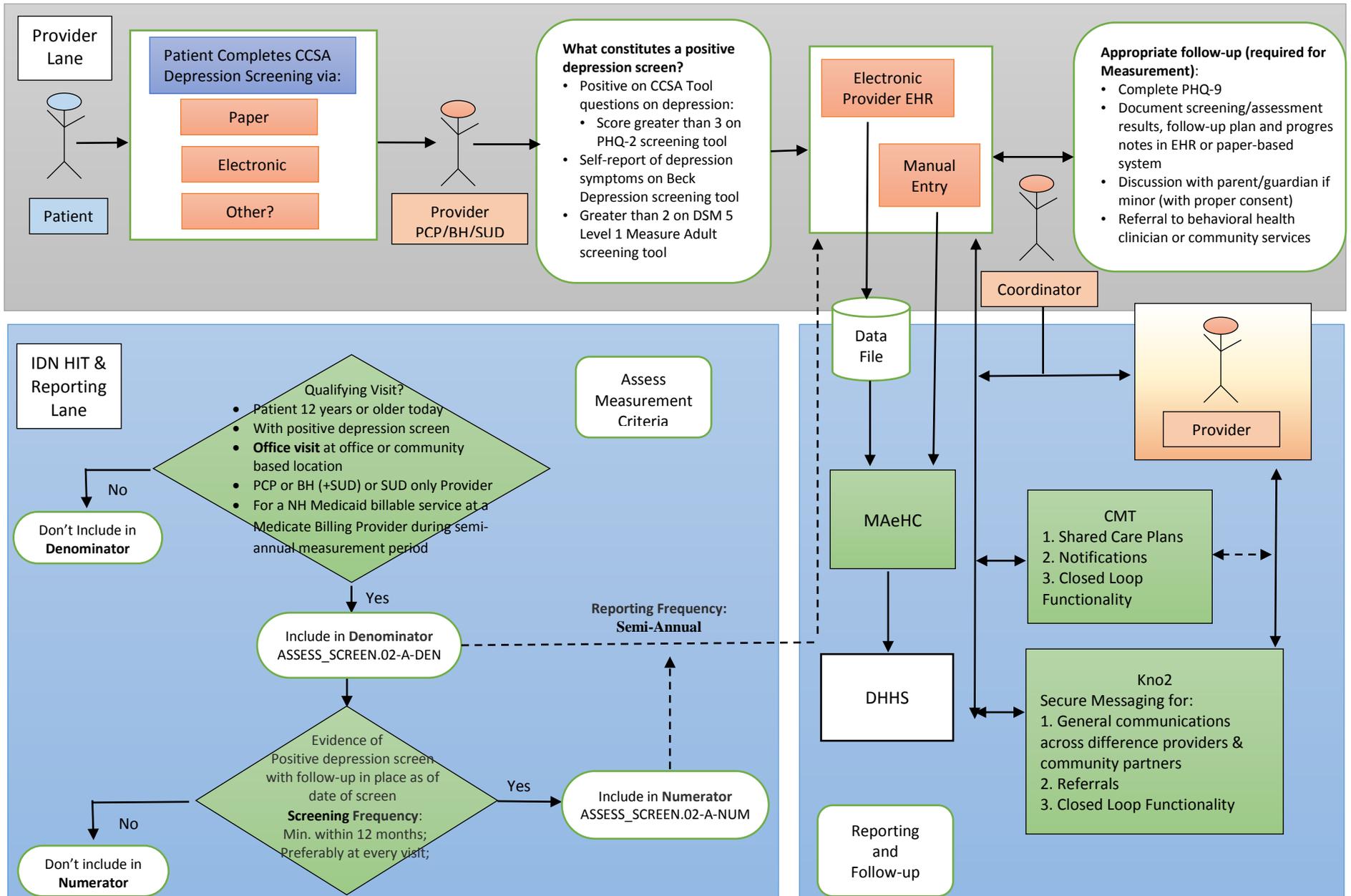


## ASSESS\_SCREEN.02 - Appropriate Follow-Up Plan for Positive Screenings for Potential Depression and/or Substance Use Disorder Policy and Protocol Considerations

<b>Sub-Measure: ASSESS_SCREEN.02-A - Depression Screening &amp; Follow-up</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
Which IDN treatment providers are required to complete screening and have a follow-up plan in place for potential <b>depression</b> diagnosis and how often?	Required IDN Member Entities (ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		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: <ul style="list-style-type: none"> <li>• Minimally: Once every 12 months</li> <li>• Preferred: Every office visit*</li> </ul>		*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 <b>depression</b> screen by the IDN?	Recommended tools/protocols (select ONE of the below): <ul style="list-style-type: none"> <li>• Positive on CCSA Tool questions on depression which are PHQ2 screening questions where a score greater than 3 is considered a positive screen</li> <li>• PHQ2 screening tool administered outside of the CCSA tool where a score greater than 3 is considered a positive screen</li> <li>• Self- report of depression symptoms on Beck Depression screening tool</li> <li>• Greater than 2 on either DSM 5 Level 1 Measure Adult screening tool (for <b>18 years and older</b>) or DSM 5 Level 1 Measure – Child Age 11-17 screening tool (for <b>12-17 years old</b>)</li> <li>• Or IDN approved evidence based question in provider's specific EHR system</li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patients 12 years old and older and enrolled in Medicaid* at the time of the visit.</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the six month measurement period.</li> <li>• Patient screening result was positive and follow-up plan in place, as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit</li> </ul> *Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.  Exclusions:  A patient is not eligible if one or more of the following conditions are documented: <ul style="list-style-type: none"> <li>• Patient refuses to participate in the follow-up plan;</li> <li>• 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;</li> </ul>	

Sub-Measure: ASSESS_SCREEN.02-A - Depression Screening & Follow-up (CONTINUED)			
Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
		<ul style="list-style-type: none"> <li>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</li> <li>Any other exclusion documented in the IDN's approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.</li> </ul>	
What constitutes an appropriate follow-up plan in place for a positive <b>depression</b> screen by the IDN?	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>Complete PHQ-9 screening tool (if using PHQ-2 or Beck Depression screening tool)</li> <li>Discuss results with parent/guardian, if patient is a minor (with proper informed consent)</li> <li>Referral to a behavioral health clinician for further treatment</li> <li>Referral to community services where appropriate</li> </ul> <p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>Document screening/assessment results, intervention/follow-up plan and progress notes in: <ul style="list-style-type: none"> <li>organization's Electronic Health Record (EHR) and/or</li> <li>paper-based system</li> </ul> </li> </ul>	Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.	
How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?	<p>Recommended IDN options for capturing and reporting appropriate follow-up plan positive depression screening:</p> <ul style="list-style-type: none"> <li>Electronic: provider attestation built into provider organization's EHR <ul style="list-style-type: none"> <li>Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of patients seen by the IDN's Medicaid billing providers in the IDN's attributed population who had a positive screen for depression with appropriate follow-up plan in place:</p> <p><b>ASSESS_SCREEN.02-A-NUM</b> (Numerator) - # of patients in the denominator with follow-up plans in place for depression  <b>ASSESS_SCREEN.02-A-DEN</b> (Denominator) - # of positive depression screenings occurring in the eligible population  <b>ASSESS_SCREEN.02-A-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>Semi-annually (every 6 months)</li> </ul>	Per DSRIP measures, this measure only assesses whether the follow-up plan is <b>in place</b> for positive depression screenings. It does not assess whether screening occurred or whether any follow-up plan has actually been carried out by the patient.

## Sub-Measure: ASSESS\_SCREEN.02-A - Depression Screening with Follow-up In Place Component Flow

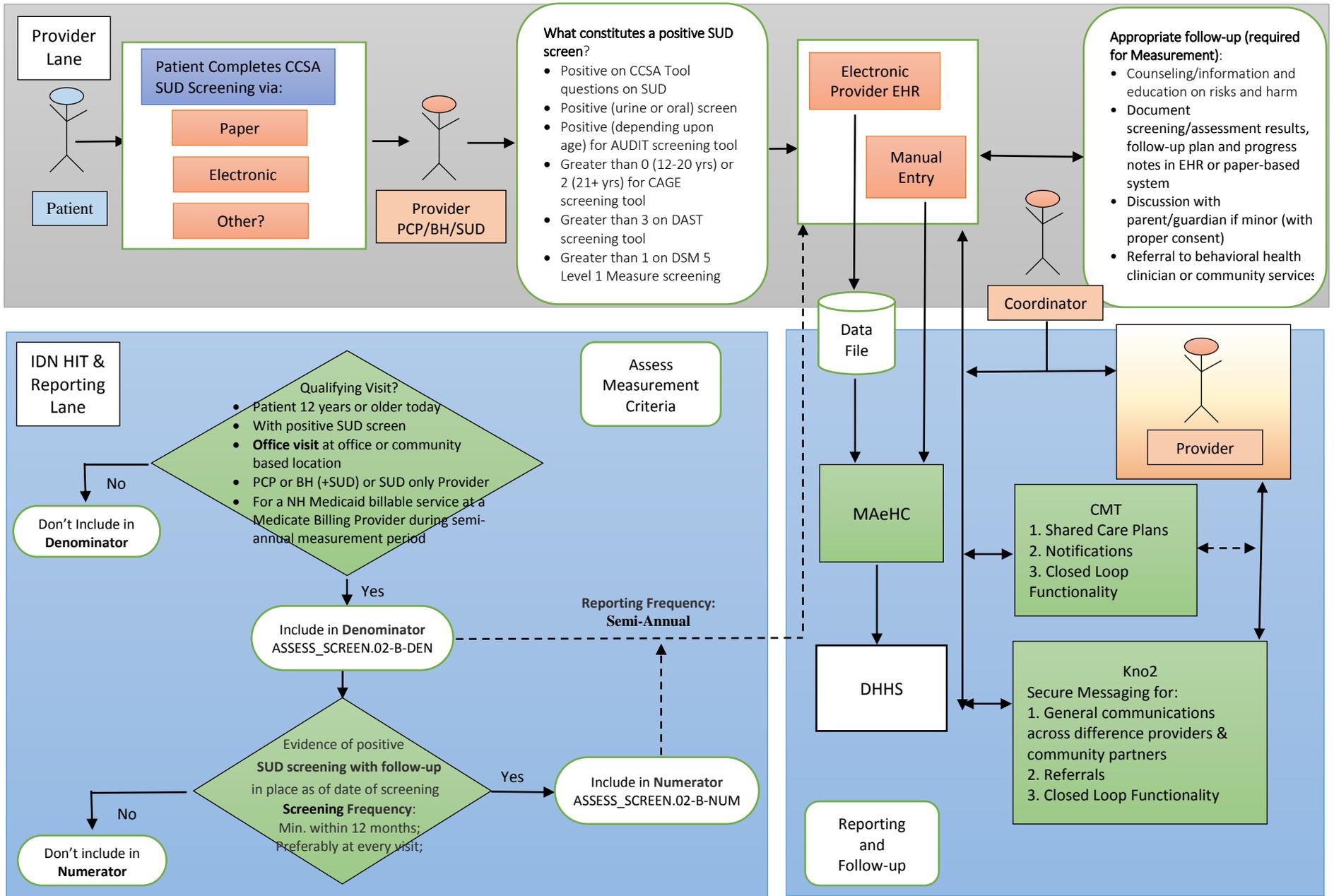


<b>Sub-Measure: ASSESS_SCREEN.02-B - Substance Use Disorder Screening &amp; Follow-up</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
Which IDN treatment providers are required to complete and have a follow-up plan in place for potential <b>alcohol and illicit substance use disorder</b> diagnosis and how often?	<p>Required IDN Member Entities (ALL of the below):</p> <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		<p>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</p> <p>Per DSRIP measures, all IDN primary care and behavioral health provider partners must report data for this measure.</p>
	<p>Recommended frequency:</p> <ul style="list-style-type: none"> <li>• Minimally: Once every 12 months</li> <li>• Preferred: Every office visit*</li> </ul>		<p>*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</p>
What constitutes approved tools and a positive <b>alcohol screen use (for 12-20 years of age)</b> by the IDN?	<p>Recommended tools/protocols (select ONE of the below):</p> <ul style="list-style-type: none"> <li>• Anything other than Never to any of the alcohol related questions on CCSA tool</li> <li>• Any positive answer to any of the AUDIT screening questions should be followed up</li> <li>• Greater than 0 for CAGE screening tool</li> <li>• Positive on Brief Intervention (S2BI) question on alcohol use</li> <li>• Positive on DSM 5 Level 1 Measure – Child 11-17 screening tool on alcohol use</li> <li>• Positive to Brief Intervention and Referral to Treatment (SBIRT) for Youth</li> <li>• Or IDN approved evidence based question in provider's specific EHR system</li> </ul>	<p>Eligibility (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Patients 12 years old and older and enrolled in Medicaid* at the time of the visit.</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the six month measurement period.</li> <li>• Patient screening result was positive and follow-up plan in place, as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit</li> </ul> <p>*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.</p>	
What constitutes approved tools and a positive <b>alcohol use screen (for 21 years of age and older)</b> by the IDN?	<p>Recommended tools/protocols (select ONE of the below):</p> <ul style="list-style-type: none"> <li>• Yes to one or more days of heavy drinking (5 or more in a day) on CCSA tool</li> <li>• Greater than 6 or 7 for AUDIT screening tool</li> <li>• Greater than 2 for CAGE screening tool</li> <li>• Positive on DSM 5 Level 1 Measure - Adult screening tool on alcohol use</li> <li>• Positive on Brief Intervention (S2BI) question on alcohol use</li> <li>• Positive to Brief Intervention and Referral to Treatment (SBIRT) for Adults</li> </ul>	<p>Exclusions:</p> <p>A patient is not eligible if one or more of the following conditions are documented:</p> <ul style="list-style-type: none"> <li>• Patient refuses to participate in the follow-up plan;</li> <li>• 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;</li> <li>• 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</li> <li>• Any other exclusion documented in the IDN's approved implementation project plan and</li> </ul>	

<b>Sub-Measure: ASSESS_SCREEN.02-B - Substance Use Disorder Screening &amp; Follow-up (CONTINUED)</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
What constitutes approved tools and a positive <b>illicit substance use</b> screen by the IDN?	<p>Recommended tools/protocols (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Yes to any use of illegal drugs or misuse of prescription drugs on CCSA tool</li> <li>• Yes to any use of illegal or misuse of prescription drugs on NIDA Quick Screen</li> <li>• Positive (urine or oral) screen for misuse</li> <li>• Greater than 3 on DAST screening tool</li> <li>• Positive on either DSM 5 Level 1 Measure Adult screening tool (for <b>18 years and older</b>) or DSM 5 Level 1 Measure – Child Age 11-17 screening tool (for <b>12-17 years old</b>) on illegal drugs use or misuse of prescription drugs</li> <li>• Monthly use of illicit substances on S2BI</li> <li>• Positive to Brief Intervention (SBIRT) Screen</li> </ul>	<ul style="list-style-type: none"> <li>• Any other exclusion documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare</li> </ul>	
What constitutes an appropriate follow-up plan in place for a positive <b>substance use disorder</b> screen by the IDN?	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Brief counseling/information and education on risks and harm</li> <li>• Conduct DAST screening/assessment as follow-up, if not used initially</li> <li>• Provide “warm hand-off” to behavioral health specialist/clinician for further assessment</li> <li>• Refer to a “higher level of care”</li> <li>• Offer pharmacotherapy</li> <li>• Referral to BH or Social Worker or Community Services</li> <li>• Discuss results with parent/guardian, if patient is a minor (with proper informed consent)</li> </ul>	Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.	
	<p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in: <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>		

<b>Sub-Measure: ASSESS_SCREEN.02-B - Substance Use Disorder Screening &amp; Follow-up (CONTINUED)</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?	<p>Recommended IDN options for capturing and reporting appropriate follow-up plan for positive SUD screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization's EHR <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of patients seen by the IDN's Medicaid billing providers in the IDN's attributed population who had a positive screen for SUD with appropriate follow-up plan in place:</p> <p><b>ASSESS_SCREEN.02-B-NUM</b> (Numerator) - # of patients in the denominator with follow-up plans in place for positive SUD during the reporting period  <b>ASSESS_SCREEN.02-B-DEN</b> (Denominator) - # of positive SUD screenings occurring in the eligible population  <b>ASSESS_SCREEN.02-B-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Semi-annually (every 6 months)</li> </ul>	<p>Per DSRIP measures, this measure only assesses whether the follow-up plan is <b>in place</b> for positive depression screenings. It does not assess whether screening occurred or whether any follow-up plan has actually been carried out by the patient.</p>

## Sub-Measure: ASSESS\_SCREEN.02-B - Substance Use Disorder Screening with Follow-up In Place Component Flow



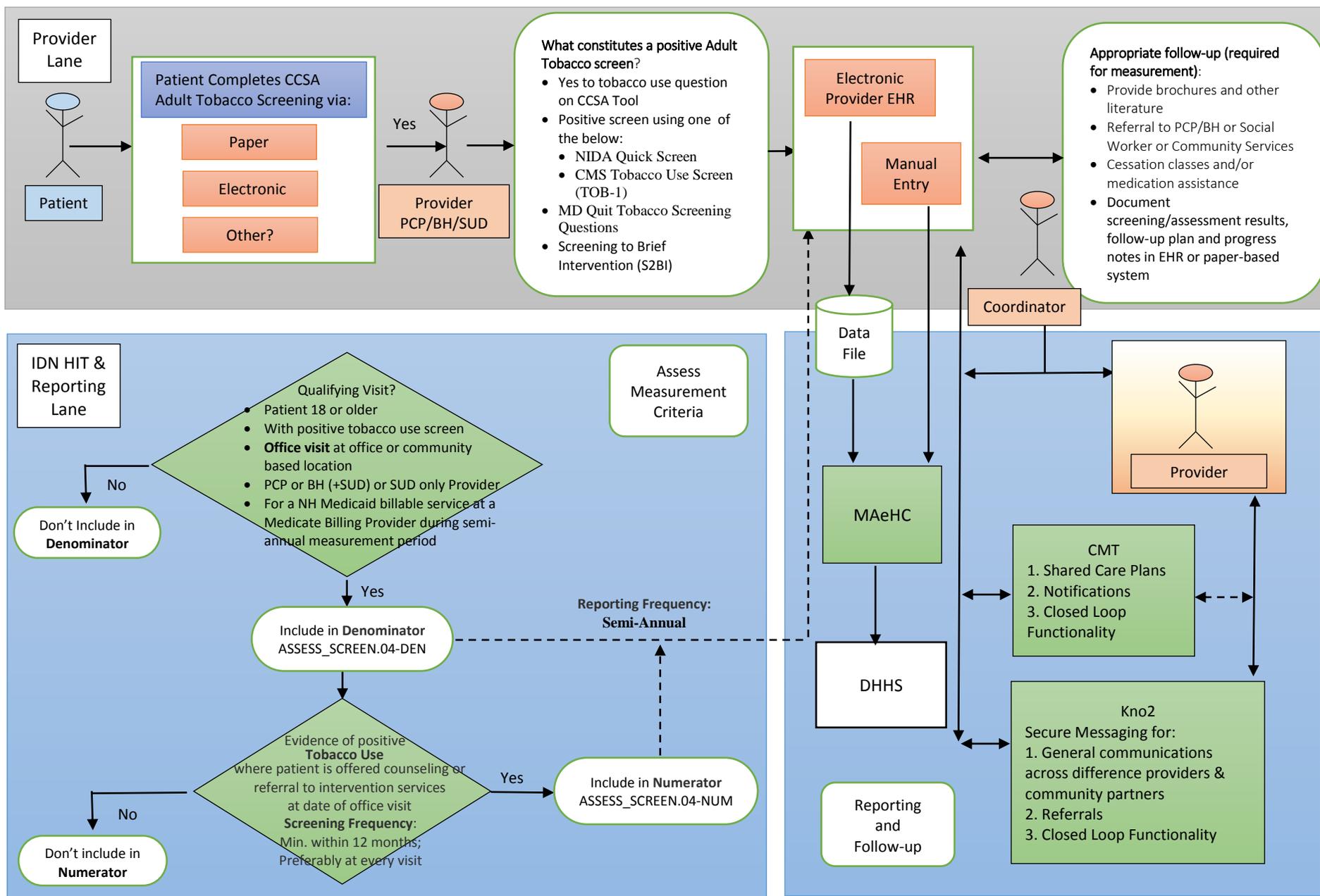
**ASSESS\_SCREEN.04 – Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by the IDN’s Medicaid Billing Providers Policy and Protocol Considerations**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
Which IDN treatment providers will be required to complete screening for Medicaid patients in in office or community based settings for <b>adult smoking and tobacco use with appropriate counseling provided</b> and how often?	Required IDN Member Entities (all of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		Tobacco Use screening must be completed and counseling must be documented in the patient’s electronic health record (EHR) on the date of the positive screening. All IDN primary care and behavioral health provider partners must report data for this measure, which has two sub-measures.
	Recommended frequency: <ul style="list-style-type: none"> <li>• Minimally: Once every 12 months</li> <li>• Preferred: Every office visit*</li> </ul>		*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 a positive screening for <b>adult smoking and tobacco use</b> ?	Recommended tools/protocols (select ONE or MORE below): <ul style="list-style-type: none"> <li>• Positive on CCSA Tool question on tobacco use</li> <li>• Positive on NIDA Quick Screen question on tobacco use</li> <li>• CMS Tobacco Use Screen (TOB-1)</li> <li>• MD Quit Tobacco Screening Questions</li> <li>• Positive on either DSM 5 Level 1 Measure Adult screening tool (for <b>18 years and older</b>) or DSM 5 Level 1 Measure – Child Age 11-17 screening tool (for <b>12-17 years old</b>) question on tobacco use</li> <li>• Positive to Brief Intervention (S2BI) question on tobacco use</li> <li>• Screening, Brief Intervention and Referral to Treatment (SBIRT)</li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patients 18 years old and older and enrolled in Medicaid* at the time of the visit.</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the six month measurement period.</li> <li>• Patient screening result was positive and counseling provided to prevent smoking, as indicated in the patient’s electronic health record (EHR) or other tracking system at the end of the visit</li> </ul> *Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.	

**ASSESS\_SCREEN.04 - Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by the IDN's Medicaid Billing Providers Policy and Protocol Considerations (CONTINUED)**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>What constitutes an appropriate follow-up plan for a positive screening for <b>adult smoking and tobacco use</b>?</p>	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Conduct assessment on readiness to change/brief counseling</li> <li>• Brief intervention: education materials provided (pamphlet/handout for “10 steps to quit smoking”)</li> <li>• Referral to cessation classes/programs</li> <li>• Referral to smoking cessation groups</li> <li>• Pharmacotherapy offered</li> </ul> <p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in:                             <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>	<p>Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.</p>	
<p>How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?</p>	<p>Recommended IDN options for capturing and reporting appropriate follow-up plan for positive SUD screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR                             <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager                             <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of patients seen by the IDN's Medicaid billing providers who had an adult tobacco screening and applicable counseling offered:</p> <p><b>ASSESS_SCREEN.04-NUM</b> (Numerator) - # of patients in the denominator with an appropriate follow-up plan  <b>ASSESS_SCREEN.04-DEN</b> (Denominator) # patients 18 and older with a positive screening of tobacco use, seen during the measurement period  <b>ASSESS_SCREEN.04-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Semi-annually (every 6 months)</li> </ul>	<p>IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.</p>

## ASSESS\_SCREEN.04 – Adult Tobacco Screening with Applicable Counseling Component Flow



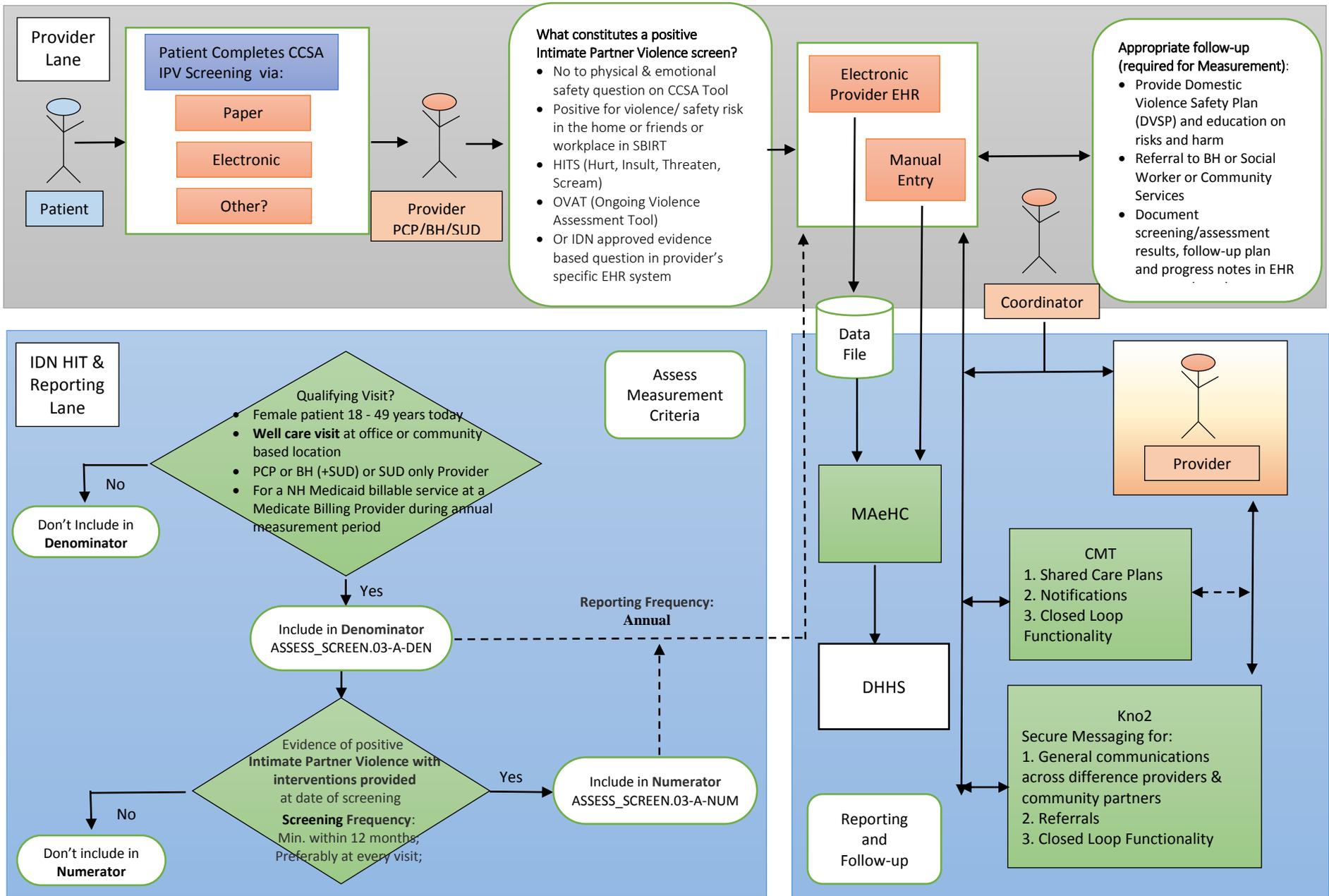
ASSESS\_SCREEN.03 - Selected US Preventive Services Task Force Services for Behavioral Health Population  
Policy and Protocol Considerations

Sub-Measure: ASSESS_SCREEN.03_Sub_A – Intimate Partner Violence (IPV) Screening and Applicable Referrals			
Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
Which IDN treatment providers are required to complete and have a follow-up plan in place for potential <b>intimate partner violence</b> diagnosis for <b>females</b> and how often?	Required IDN Member Entities (ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		Per DSRIP measures, all IDN primary care and behavioral health provider partners must report data for this measure.
	Recommended frequency: <ul style="list-style-type: none"> <li>• Minimally: Once every 12 months</li> <li>• Preferred: Every office visit*</li> </ul>		*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 <b>intimate partner violence</b> screen by the IDN?	Recommended tools/protocols (select ONE of the below): <ul style="list-style-type: none"> <li>• No to physical &amp; emotional safety question on CCSA Tool</li> <li>• Positive for violence/ safety risk in the home or friends or workplace in SBIRT</li> <li>• Positive on other recommended tools               <ul style="list-style-type: none"> <li>○ HITS (Hurt, Insult, Threaten, Scream)</li> <li>○ OVAT (Ingoing Violence Assessment Tool)</li> <li>○ STaT (Slapped, Things and Threaten)</li> <li>○ HARK (Humiliation, Afraid, Rape, Kick)</li> <li>○ CTQ–SF (Modified Childhood Trauma Questionnaire–Short Form)</li> <li>○ WAST (Woman Abuse Screen Tool)</li> </ul> </li> <li>• Or IDN approved evidence based question in provider’s specific EHR system</li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• FEMALES age 18 through 49 and enrolled in Medicaid* at the time of the visit.</li> <li>• Seen by an IDN partner primary care or behavioral health care provider for a well-care visit during the calendar year.</li> <li>• Screened for intimate partner violence and provided intervention(s) for positive results, as indicated in the patient’s electronic health record (EHR) or other tracking system at the end of the visit</li> </ul> <p>*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.</p> <p>DHHS Determination of Attributed Behavioral Health Population:</p> <ul style="list-style-type: none"> <li>• DHHS will supply person specific detail of each IDN’s attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period, with this file being used to identify which IDN patient seen during the measure data source time</li> </ul>	Per DSRIP measures, intimate partner violence screening includes physical, sexual, or psychological harm by a current or former partner or spouse. The screening must be completed and a follow-up plan must be documented in the patient’s electronic health record (EHR) on the date of the positive screening.

**Sub-Measure: ASSESS\_SCREEN.03\_Sub\_A – Intimate Partner Violence (IPV) Screening and Applicable Referrals (CONTINUED)**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>What constitutes an appropriate follow-up plan in place for a positive <b>intimate partner violence</b> screen by the IDN?</p>	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Provide Domestic Violence Safety Plan (DVSP)</li> <li>• Referral to BH or Social Worker or Community Services</li> </ul>	<p>Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.</p>	<p>Per DSRIP measures, this measure only assesses whether the follow-up plan is <b>in place</b> for positive intimate partner violence screenings. It does not assess whether screening(s) occurred or whether any follow-up plan has actually been carried out by the patient.</p>
	<p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in:                             <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>		
<p>How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?</p>	<p>Recommended IDN options for capturing and reporting appropriate follow-up plan for positive intimate partner violence screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR                             <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager                             <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of females (ages 18 – 49) in the IDN’s attributed behavioral health population seen by the IDN’s primary care or behavioral health providers for a well-care visit during the calendar year who are screened for intimate partner violence and provided interventions:</p> <p><b>ASSESS_SCREEN.03-A-NUM</b> (Numerator) - # of patients in the denominator with intimate partner violence screening and applicable referrals during the well care visit  <b>ASSESS_SCREEN.03-A-DEN</b> (Denominator) - # of females 18-49 with a <b>well care visit</b> during the measurement period  <b>ASSESS_SCREEN.03-A-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	<p>IDNs must ensure that <u>all primary care or behavioral health provider partners</u> report data for this measure to the extent the criteria for inclusion in the measure is met, even though behavioral health care providers may not provide well-care visits</p>

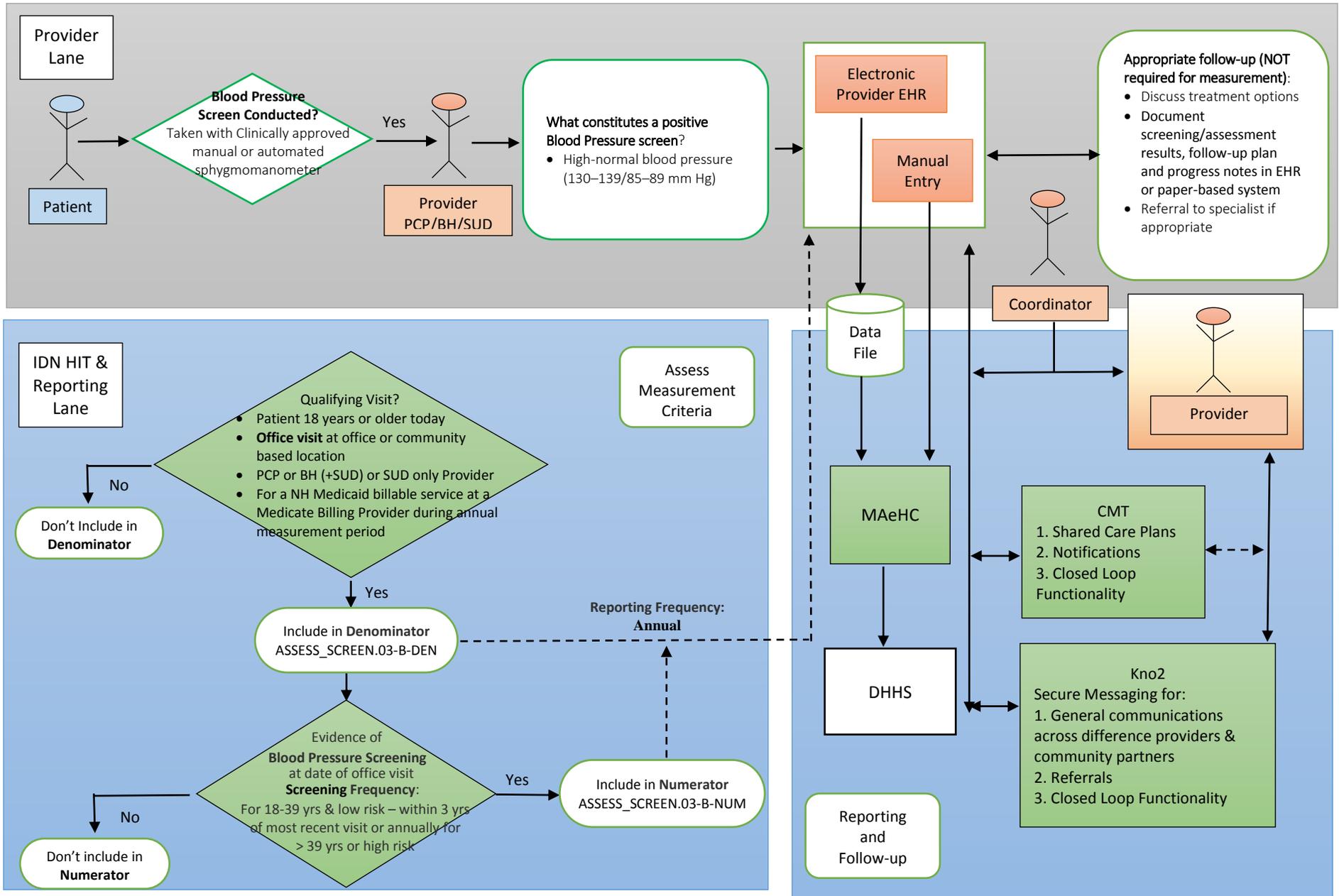
## Sub-Measure: ASSESS\_SCREEN.03\_Sub\_A – Intimate Partner Violence (IPV) Screening and Applicable Referrals Component Flow



<b>Sub-Measure: ASSESS_SCREEN.03_Sub_B – Blood Pressure Screening</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
Which IDN treatment providers are required to complete a <b>blood pressure</b> screening and how often?	Required IDN Member Entities (Select ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		
	Recommended Frequency: <ul style="list-style-type: none"> <li>• Vitals with every visit is optimal</li> <li>• age 18-39 &amp; low risk, once every 3 years age 40 years or older or high risk, annually</li> </ul>		
What constitutes approved tools and a positive high <b>blood pressure</b> screen by the IDN?	Recommended Guidelines (as per USPSTF): <ul style="list-style-type: none"> <li>• At risk for high blood pressure (&gt;130–139/85–89 mm Hg) using a clinically approved manual or automated sphygmomanometer</li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patients age 18 or older and enrolled in Medicaid* at the time of the visit - recommended guidelines: <ul style="list-style-type: none"> <li>• age 18-39 &amp; low risk, once every 3 years</li> <li>• age 40 years or older or high risk, annually</li> <li>• age 18 or older</li> </ul> </li> <li>• Who have a current blood pressure screening as indicated in the patient’s electronic health record (EHR) or other tracking system at the end of the visit</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the recommended measurement period</li> </ul> <p>*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans</p> <p>DHHS Determination of Attributed Behavioral Health Population:</p> <ul style="list-style-type: none"> <li>• DHHS will supply person specific detail of each IDN’s attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period, with this file being used to identify which IDN patient seen during the measure data source time</li> </ul>	

<b>Sub-Measure: ASSESS_SCREEN.03_Sub_B – Blood Pressure Screening (CONTINUED)</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
What constitutes an appropriate follow-up plan in place for a positive <b>blood pressure</b> screen by the IDN ( <b>not required for measurements</b> )?	Recommended IDN policy for follow-up intervention (select ONE or MORE below): <ul style="list-style-type: none"> <li>• Discuss treatment options</li> <li>• Referral to specialist if appropriate</li> </ul>	Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.	
	Recommended IDN follow-up documentation method (select ONE or MORE below): <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in: <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>		
How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?	Recommended IDN options for capturing and reporting completion of blood pressure screening: <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	Measurements required (per DSRIP measures): <p>Percent of patients seen by the IDN’s Medicaid billing providers in the IDN’s attributed behavioral health population who had a current blood pressure screen:</p> <p><b>ASSESS_SCREEN.03-B-NUM</b> (Numerator) - # of patients in the denominator with a current blood pressure screening based on age criteria  <b>ASSESS_SCREEN.03-B-DEN</b> (Denominator) - # of patients 18 and older seen during the period  <b>ASSESS_SCREEN.03-B-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	IDNs must ensure that <u>all primary care or behavioral health provider partners</u> report data for this measure to the extent the criteria for inclusion in the measure is met, even though behavioral health care providers may not provide well-care visits

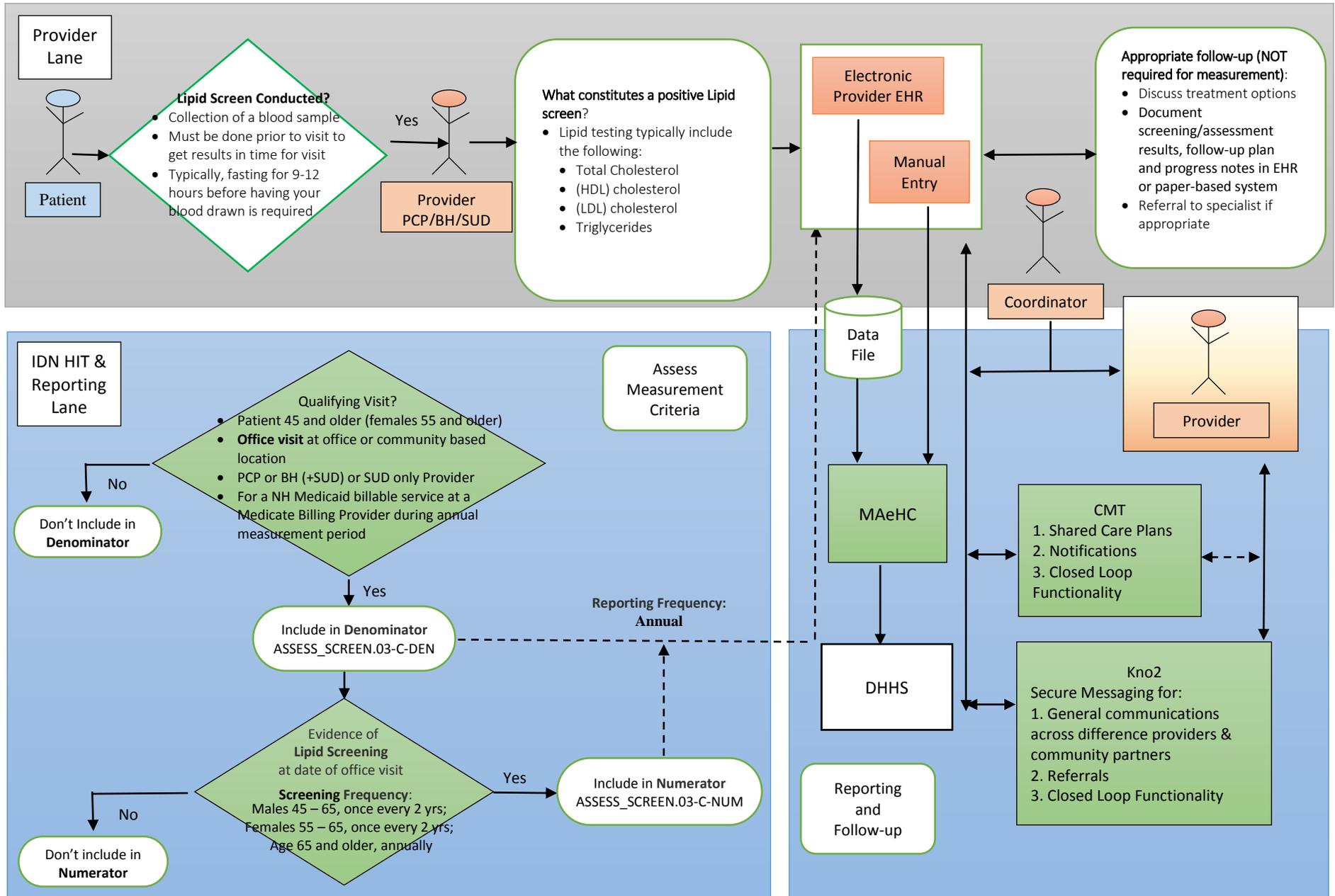
## Sub-Measure: ASSESS\_SCREEN.03\_Sub\_B – Blood Pressure Screening Component Flow



<b>Sub-Measure: ASSESS_SCREEN.03_Sub_C – Adult Lipid Screening</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
Which IDN treatment providers are required to complete an <b>adult lipid</b> screening and how often?	Required IDN Member Entities (ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		
	Recommended frequency (as per DSRIP Outcome Measures Narrative Guide*): <ul style="list-style-type: none"> <li>• Males age 45 through 65 once every 2 years;</li> <li>• Females age 55 through 65 once every 2 years;</li> <li>• Age 65 and older annually</li> </ul>		*The measure follows the American Association of Clinical Endocrinologist and American College of Endocrinology Guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease
What constitutes approved tools and a positive <b>adult lipid</b> screen by the IDN?	Recommended tools/protocols: <ul style="list-style-type: none"> <li>• Collection of a blood sample</li> <li>• Typically, fasting for 9-12 hours (water only) before having your blood drawn is required, but some labs offer non-fasting lipid testing</li> </ul> Lipid testing typically include the following: <ul style="list-style-type: none"> <li>• Total Cholesterol</li> <li>• High-density lipoprotein (HDL) cholesterol</li> <li>• Low-density lipoprotein (LDL) cholesterol</li> <li>• Triglycerides</li> </ul> Guidelines for Positive Results: <ul style="list-style-type: none"> <li>• Usage of American College of Cardiology (ASCVD) Risk Estimator</li> <li>• High Risk Considerations: dyslipidemia, high blood pressure, tobacco use, diabetes, a family history of premature coronary heart disease, older age, male gender, diet; socioeconomic status, obesity, and physical inactivity</li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patients age 45 and older (females 55 and older):               <ul style="list-style-type: none"> <li>• Males age 45 through 65 once every 2 years</li> <li>• Females age 55 through 65 once every 2 years</li> <li>• Age 65 and older annually</li> </ul> </li> <li>• Who have a current lipid screening as indicated in the patient’s electronic health record (EHR) or other tracking system at the end of the visit</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the recommended measurement period</li> </ul> *Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans  DHHS Determination of Attributed Behavioral Health Population: <ul style="list-style-type: none"> <li>• DHHS will supply person specific detail of each IDN’s attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period, with this file being used to identify which IDN patient seen during the measure data source time</li> </ul>	

<b>Sub-Measure: ASSESS_SCREEN.03_Sub_C – Adult Lipid Screening (CONTINUED)</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
What constitutes an appropriate follow-up plan in place for a positive <b>adult lipid</b> screen by the IDN ( <b>not required for measurements</b> )?	Recommended IDN follow-up documentation method (select ONE or MORE below): <ul style="list-style-type: none"> <li>• Discuss treatment options</li> <li>• Referral to specialist if appropriate</li> </ul>	Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.	
	Recommended IDN follow-up documentation method (select ONE or MORE below): <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in: <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>		
How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?	Recommended IDN options for capturing and reporting completion of lipid screening: <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	Measurements required (per DSRIP measures): <p>Percent of patients seen by the IDN’s Medicaid billing providers in the IDN’s attributed behavioral health population who had a current lipid screen:</p> <p><b>ASSESS_SCREEN.03-C-NUM</b> (Numerator) - # of patients in the denominator with a current lipid screening based on age criteria</p> <p><b>ASSESS_SCREEN.03-C-DEN</b> (Denominator) - # of patients 45 and older (females 55 and older) seen during the period</p> <p><b>ASSESS_SCREEN.03-C-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	IDNs must ensure that <u>all primary care or behavioral health provider partners</u> report data for this measure to the extent the criteria for inclusion in the measure is met, even though behavioral health care providers may not provide well-care visits

## Sub-Measure: ASSESS\_SCREEN.03\_Sub\_C – Adult Lipid Screening Component Flow

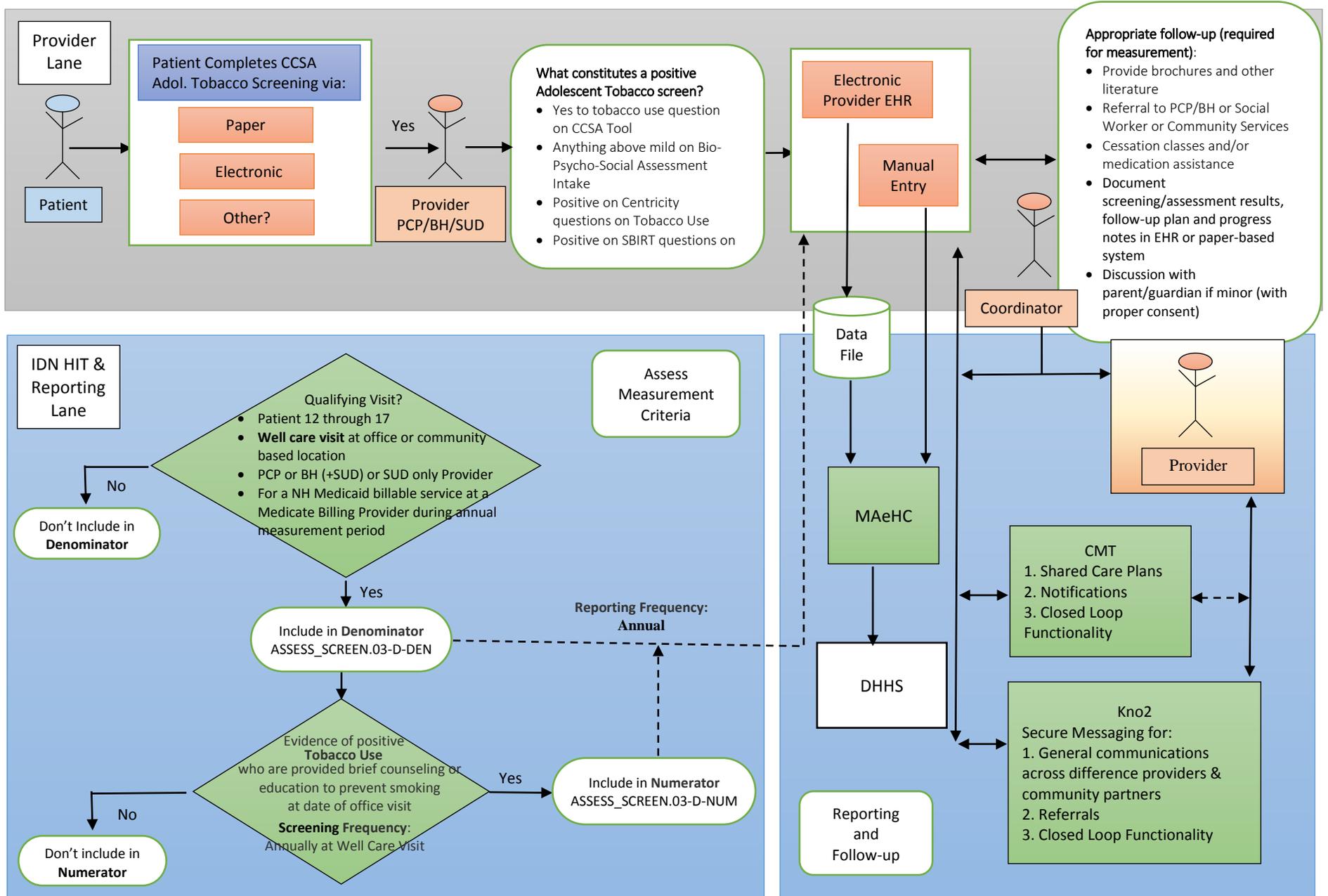


<b>Sub-Measure: ASSESS_SCREEN.03_Sub_D – Adolescent Tobacco Use Interventions</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
Which IDN treatment providers are required to complete and have a follow-up plan in place for <b>adolescent tobacco use</b> diagnosis and how often?	Required IDN Member Entities (ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		
	Recommended frequency: <ul style="list-style-type: none"> <li>• Minimally: Once every 12 months</li> <li>• Preferred: Every office visit*</li> </ul>		*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 <b>adolescent tobacco use</b> screen by the IDN?	Recommended tools/protocols (select ONE of the below): <ul style="list-style-type: none"> <li>• Yes to tobacco use question on CCSA Tool</li> <li>• Anything above mild on Bio-Psycho-Social Assessment Intake</li> <li>• Or IDN approved evidence based question in provider’s specific EHR system</li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patient age 12 through 17 and enrolled in Medicaid* at the time of the visit</li> <li>• Screened for adolescent tobacco use and provided interventions for positive results, as indicated in the patient’s electronic health record (EHR) or other tracking system at the end of the visit</li> <li>• Seen by an IDN partner primary care or behavioral health care provider for a well-care visit during the calendar year</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the annual measurement period</li> </ul> *Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans  DHHS Determination of Attributed Behavioral Health Population: <ul style="list-style-type: none"> <li>• DHHS will supply person specific detail of each IDN’s attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period, with this file being used to identify which IDN patient seen during the measure data source time</li> </ul>	

**Sub-Measure: ASSESS\_SCREEN.03\_Sub\_D – Adolescent Tobacco Use Interventions (CONTINUED)**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>What constitutes an appropriate follow-up plan in place for a positive for <b>adolescent tobacco use</b> screen by the IDN?</p>	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Provide brochures and other literature</li> <li>• Referral to PCP/BH or Social Worker or Community Services</li> <li>• Cessation classes and/or medication assistance programs</li> <li>• Discuss results with parent/guardian, if patient is a minor (with proper informed consent)</li> </ul> <p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in:                             <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>	<p>Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.</p>	
<p>How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?</p>	<p>Recommended IDN options for capturing and reporting appropriate follow-up plan for positive adolescent tobacco screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR                             <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager                             <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of patients seen by the IDN's Medicaid billing providers in the IDN's attributed behavioral health population who had adolescent tobacco screen and counseling:</p> <p><b>ASSESS_SCREEN.03-D-NUM</b> (Numerator) - # of patients in the denominator with a brief counseling and education to prevent smoking at the end of the well care visit</p> <p><b>ASSESS_SCREEN.03-D-DEN</b> (Denominator) - # of patients age 12-17 with a <b>well care visit</b> during the measurement period</p> <p><b>ASSESS_SCREEN.03-D-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	<p>IDNs must ensure that <u>all primary care or behavioral health provider partners</u> report data for this measure to the extent the criteria for inclusion in the measure is met, even though behavioral health care providers may not provide well-care visits</p>

## Sub-Measure: ASSESS\_SCREEN.03\_Sub\_D – Adolescent Tobacco Use Interventions Component Flow



Sub-Measure: ASSESS_SCREEN.03_Sub_E – Adult Obesity Screening and Counseling			
Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
Which IDN treatment providers are required to complete and have a follow-up plan in place for potential <b>adult obesity</b> diagnosis and how often?	Required IDN Member Entities (ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		
	Recommended frequency: <ul style="list-style-type: none"> <li>• Annually at well care visit</li> </ul>		
What constitutes approved tools and a positive <b>adult obesity</b> screen by the IDN?	Recommended guidelines: <ul style="list-style-type: none"> <li>• Patients with a body mass index (BMI)* of 30 kg/m<sup>2</sup> or higher</li> </ul> <p>*Measure of height and weight contributing to Body Mass Index (BMI) calculation as part of provider EHR Tool</p>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patients age 18 and older and enrolled in Medicaid* at the time of the visit</li> <li>• Screened for obesity and applicable counseling offered for positive results, as indicated in the patient’s electronic health record (EHR) or other tracking system at the end of the visit</li> <li>• Seen by an IDN partner primary care or behavioral health care provider for a well-care visit during the calendar year</li> <li>• Seen for a NH Medicaid billable service by an IDN primary care or behavioral health care provider during the recommended measurement period</li> </ul> <p>*IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.</p> <p>DHHS Determination of Attributed Behavioral Health Population:</p> <p>DHHS will supply person specific detail of each IDN’s attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period, with this file being used to identify which IDN patient seen during the measure data source time</p>	

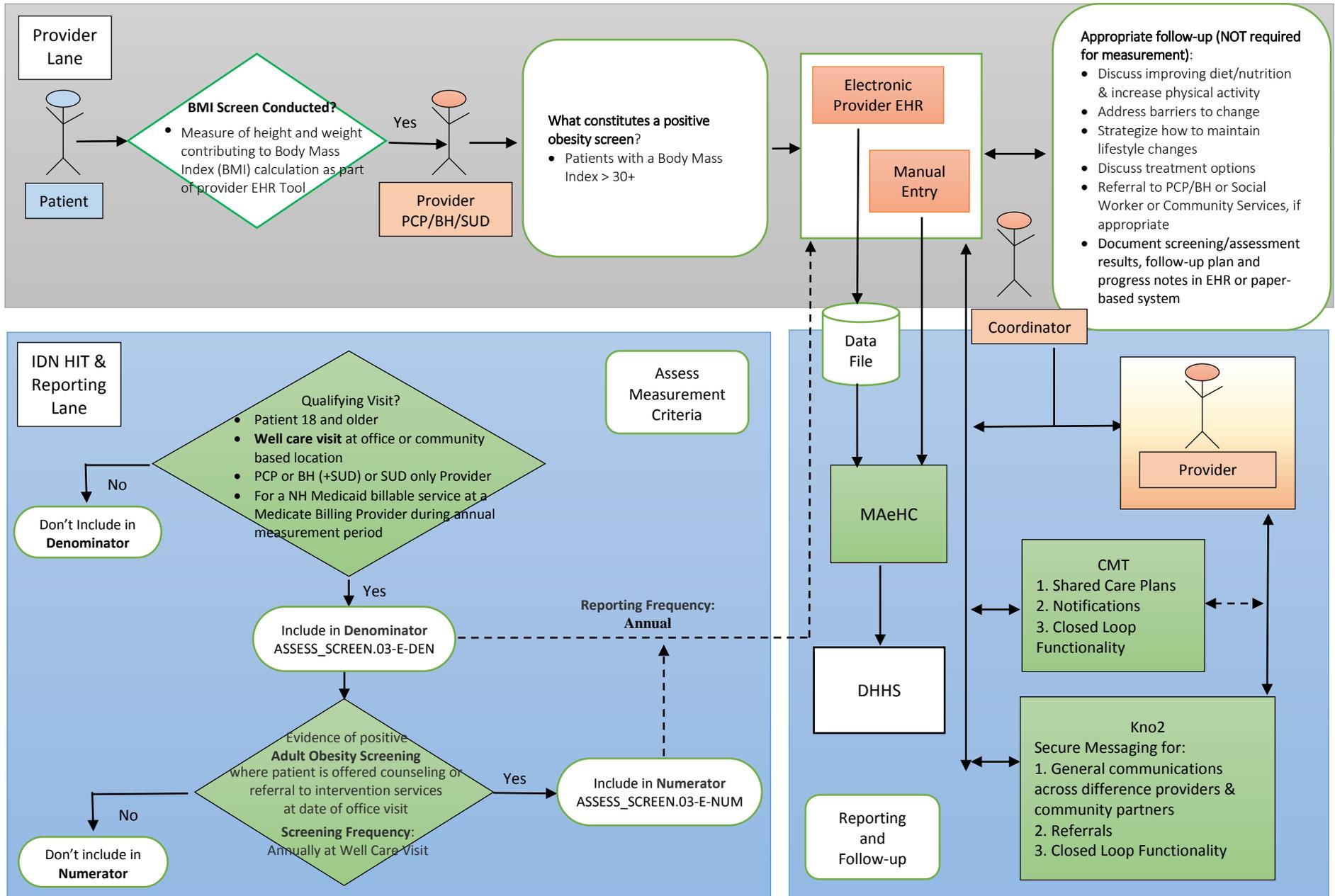
**Sub-Measure: ASSESS\_SCREEN.03\_Sub\_E – Adult Obesity Screening and Counseling - CONTINUED**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>What constitutes an appropriate follow-up plan in place for a positive <b>adult obesity</b> screen by the IDN?</p>	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <p>As per USPSTF, patients should be offered referrals to an intensive multi-component behavioral health intervention to promote improvement in weight which could include the following components:</p> <ul style="list-style-type: none"> <li>• Behavioral management activities, such as setting weight-loss goals</li> <li>• Improving diet or nutrition and increasing physical activity</li> <li>• Addressing barriers to change</li> <li>• Self-monitoring</li> <li>• Strategizing how to maintain lifestyle changes</li> </ul> <p>In addition, the following can be offered:</p> <ul style="list-style-type: none"> <li>• Provide brochures and other literature</li> <li>• Referral to PCP/BH or Social Worker or Community Services</li> <li>• Referral to specialist if appropriate</li> </ul>	<p>Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.</p>	
	<p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in:                             <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>		

**Sub-Measure: ASSESS\_SCREEN.03\_Sub\_E – Adult Obesity Screening and Counseling - CONTINUED**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?</p>	<p>Recommended IDN options for capturing and reporting completion of lipid screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR                             <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager                             <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of patients seen by the IDN’s Medicaid billing providers in the IDN’s attributed behavioral health population who had an obesity screen and applicable counseling offered:</p> <p><b>ASSESS_SCREEN.03-E-NUM</b> (Numerator) - # patients in the denominator with a current screening and applicable referrals at the end of the well care visit</p> <p><b>ASSESS_SCREEN.03-E-DEN</b> (Denominator) - # of patients age 18 and older with a <b>well care visit</b> during the measurement period</p> <p><b>ASSESS_SCREEN.03-E-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	<p>IDNs must ensure that <u>all primary care or behavioral health provider partners</u> report data for this measure to the extent the criteria for inclusion in the measure is met, even though behavioral health care providers may not provide well-care visits</p>

## Sub-Measure: ASSESS\_SCREEN.03\_Sub\_E – Adult Obesity Screening and Counseling Component Flow



**Sub-Measure: ASSESS\_SCREEN.03\_Sub\_F – Child Obesity and Overweight Screening and Counseling**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>Which IDN treatment providers are required to complete and have a follow-up plan in place for potential <b>child obesity</b> diagnosis and how often?</p>	<p>Required IDN Member Entities (ALL of the below):</p> <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul> <p>Recommended frequency:</p> <ul style="list-style-type: none"> <li>• Annually at well care visit</li> </ul>		
<p>What constitutes approved tools and a positive <b>child obesity</b> screen by the IDN?</p>	<p>Recommended guidelines:</p> <ul style="list-style-type: none"> <li>• Patients with a Body Mass Index (BMI)* &gt; 95<sup>th</sup> percentile for age and gender</li> </ul> <p>*Measure of height and weight contributing to Body Mass Index (BMI) calculation as part of provider EHR Tool</p>	<p>Eligibility (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Patient age 6 through 17</li> <li>• Seen by an IDN partner primary care or behavioral health care provider for a well-care visit during the calendar year</li> <li>• Screened for an obesity and applicable referrals offered for positive results, as indicated in the patient’s electronic health record (EHR) or other tracking system at the end of the visit</li> </ul> <p>*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.</p> <p>DHHS Determination of Attributed Behavioral Health Population:</p> <p>DHHS will supply person specific detail of each IDN’s attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period, with this file being used to identify which IDN patient seen during the measure data source time</p>	

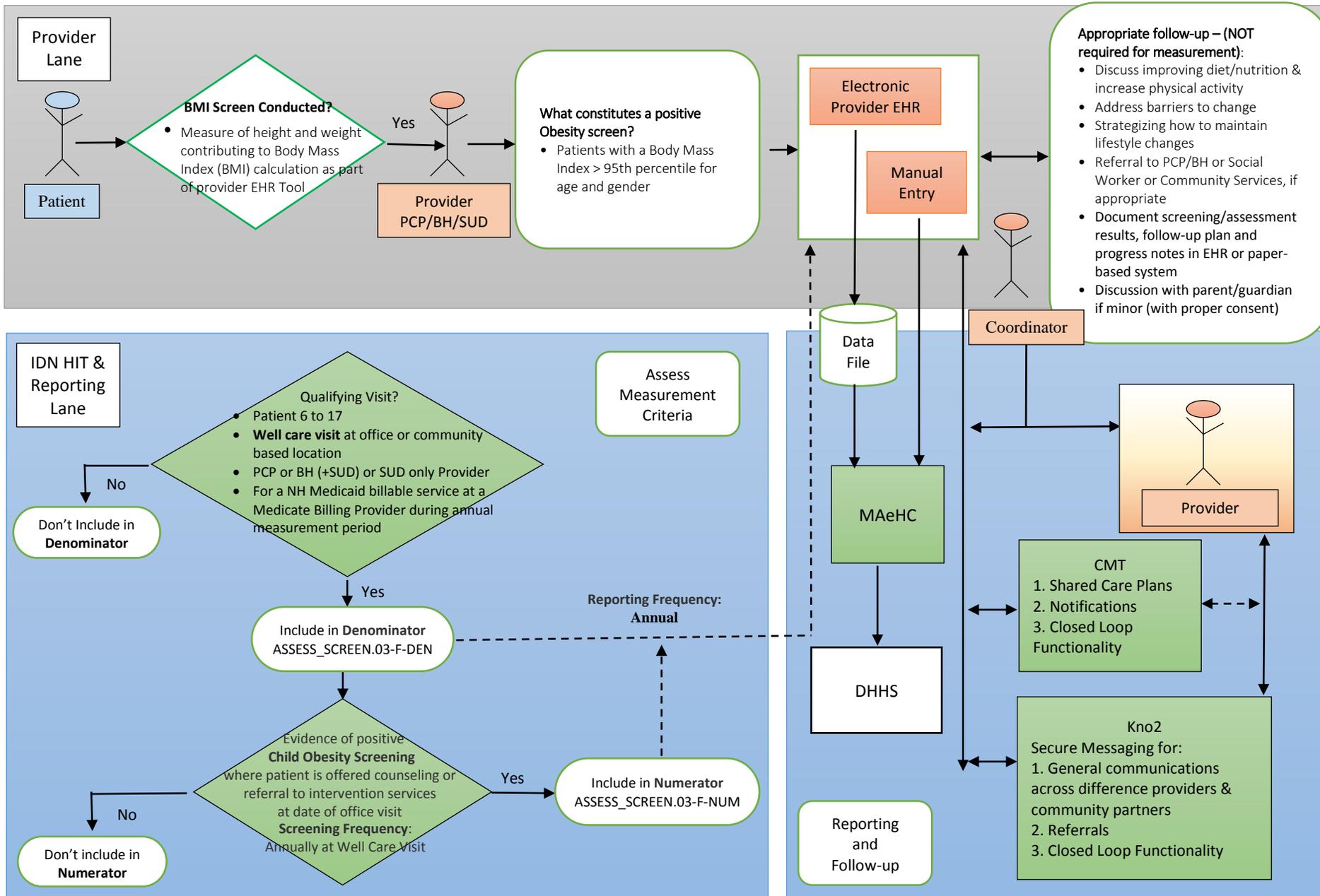
**Sub-Measure: ASSESS\_SCREEN.03\_Sub\_F – Child Obesity and Overweight Screening and Counseling – (CONTINUED)**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>What constitutes an appropriate follow-up plan in place for a positive <b>child obesity</b> screen by the IDN?</p>	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <p>As per USPSTF, should be offered referrals to an intensive multi-component behavioral health intervention to promote improvement in weight which could include the following components:</p> <ul style="list-style-type: none"> <li>• Behavioral management activities, such as setting weight-loss goals</li> <li>• Improving diet or nutrition and increasing physical activity</li> <li>• Addressing barriers to change</li> <li>• Self-monitoring</li> <li>• Strategizing how to maintain lifestyle changes</li> </ul> <p>In addition, the following can be offered:</p> <ul style="list-style-type: none"> <li>• Provide brochures and other literature</li> <li>• Referral to PCP/BH or Social Worker or Community Services</li> <li>• Referral to specialist if appropriate</li> <li>• Discuss results with parent/guardian, if patient is a minor (with proper informed consent)</li> </ul>	<p>Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.</p>	
	<p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in: <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>		

**Sub-Measure: ASSESS\_SCREEN.03\_Sub\_F – Child Obesity and Overweight Screening and Counseling – (CONTINUED)**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?</p>	<p>Recommended IDN options for capturing and reporting appropriate follow-up plan for positive intimate partner violence screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR               <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager               <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of patients seen by the IDN's Medicaid billing providers in the IDN's attributed behavioral health population who had an obesity screening and applicable counseling offered:</p> <p><b>ASSESS_SCREEN.03-F-NUM</b> (Numerator) - # patients in the denominator with a current screening and applicable referrals at the end of the well care visit</p> <p><b>ASSESS_SCREEN.03-F-DEN</b> (Denominator) - # of patients age 6 through 17 with a <b>well care visit</b> during the measurement period</p> <p><b>ASSESS_SCREEN.03-F-RATE</b> (Percent) - Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	<p>IDNs must ensure that <u>all primary care or behavioral health provider partners</u> report data for this measure to the extent the criteria for inclusion in the measure is met, even though behavioral health care providers may not provide well-care visits.</p>

## Sub-Measure: ASSESS\_SCREEN.03\_Sub\_F – Child Obesity and Overweight Screening and Counseling Component Flow

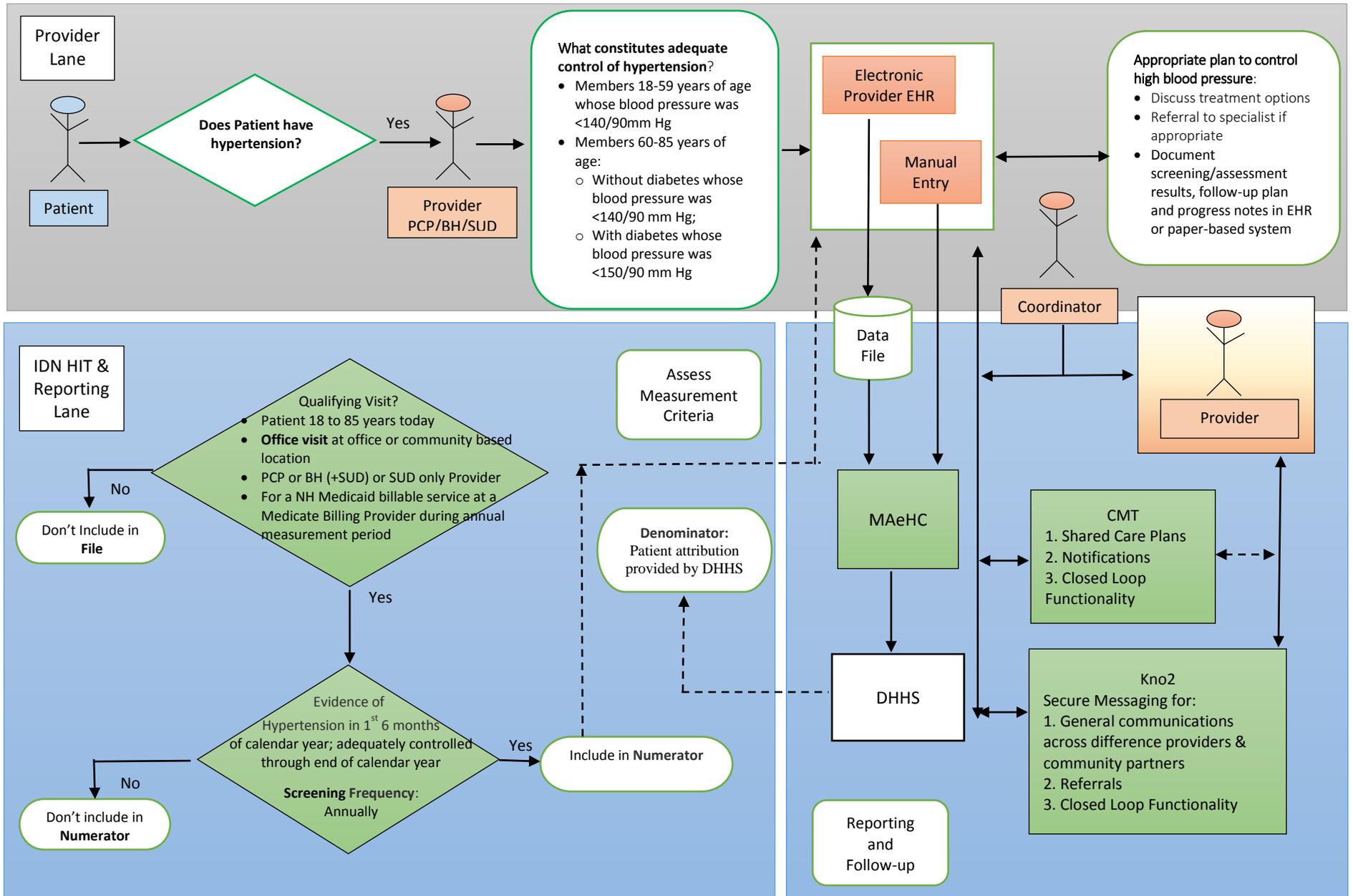


## CARE.03 - Physical Health-Focused Measures for Behavioral Health Population

<b>Sub-Measure: CARE.03_Sub_A – Controlling High Blood Pressure</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
Which IDN treatment providers are required to screen and provide options and monitoring to control <b>high blood pressure</b> and how often?	Required IDN Member Entities (Select ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul>		Intent of this HEDIS (CBP)* measure is to determine percent of Medicaid patients in the IDN’s attributed behavioral health population age 18 through 85 who had a diagnosis of hypertension in the first six months of the calendar year and whose blood pressure was adequately controlled following the diagnosis through the end of the calendar year.  *Please refer to HEDIS Volume 2 Technical Specifications for Health Plan for granular details and detailed specifications on this measure
	Recommended Frequency: <ul style="list-style-type: none"> <li>• Vitals with every visit is optimal</li> <li>• age 18-39 &amp; low risk, once every 3 years</li> <li>• age 40 years or older or high risk, annually</li> </ul>		
What constitutes adequate control of positive <b>high blood pressure</b> screen by the IDN?	Recommended Guidelines (as per DSRIP Outcome Measures Narrative Guide -HEDIS measures*):  Using a clinically approved manual or automated sphygmomanometer: <ul style="list-style-type: none"> <li>• Members 18-59 years of age whose blood pressure was &lt;140/90mm Hg</li> <li>• Members 60-85 years of age:                             <ul style="list-style-type: none"> <li>○ Without diabetes whose blood pressure was &lt;140/90 mm Hg;</li> <li>○ With diabetes whose blood pressure was &lt;150/90 mm Hg</li> </ul> </li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patients age 18 to 85 (at end of the calendar year) and continuously enrolled in Medicaid* for the entire calendar year, with only one gap of up to 45 days allowable in the attributed** IDN behavioral health population</li> <li>• With a diagnosis of hypertension in the first six months of the calendar year</li> <li>• whose blood pressure was adequately controlled following the diagnosis through the end of the calendar year</li> <li>• Seen for a NH Medicaid billable service office visit by an IDN primary care or behavioral health care provider during the recommended measurement period</li> </ul> <p>*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans including Premium Assisted Programs</p> <p>Exclusions:</p> <p>Members:</p> <ul style="list-style-type: none"> <li>• In hospice; or</li> <li>• Receiving Medicare and age 65 as of January 1 of the measurement who are residing in a long term care facility (e.g., nursing home, assisted living, hospice) any time during the measurement period;</li> <li>• Members with gestational diabetes.</li> </ul> <p>Blood pressure readings when taken:</p> <ul style="list-style-type: none"> <li>• During an acute inpatient stay or at an ED visit;</li> <li>• On the same day</li> <li>• By the member</li> </ul>	**Attributed population is determined at the end of the calendar year by DHHS. DHHS will provide a sample of members to each IDN. The IDN will provide DHHS with the results of each member’s most recent blood pressure reading through electronic health records data. Blood pressure readings will be identified through IDN electronic health record data. Diagnosis of hypertension will be identified using ICD-10 codes in claims and encounter data. IDNs may gain credit for a numerator compliant reading provided by another IDN

<b>Sub-Measure: CARE.03_Sub_A – Controlling High Blood Pressure (CONTINUED)</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
What constitutes an appropriate follow-up plan for adequately controlling <b>high blood pressure</b> by the IDN?	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Discuss treatment options</li> <li>• Referral to specialist if appropriate</li> </ul>	Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.	
	<p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in: <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>		
How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?	<p>Recommended IDN options for capturing and reporting completion of blood pressure screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>The summary score is calculated by DHHS by combining the numerators and denominators of four physical health HEDIS measures, one of which is CARE.03_SUB_A:</p> <p><b>CARE.03-A-NUM</b> (Numerator) - # of patients age 18 – 85 years old with a positive hypertension diagnosis and blood pressure was adequately controlled following the diagnosis through the end of the calendar year in the IDN’s attributed behavioral health population</p> <p><b>CARE.03-B-DEN</b> (Denominator) patient attribution provided by DHHS</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	<p>The four physical health HEDIS measures are (note, identifiers Sub B, D, E are no longer used):</p> <ul style="list-style-type: none"> <li>• CARE.03_SUB_A – Controlling High Blood Pressure – IDN reporting required</li> <li>• CARE.03_SUB_C – HbA1c Control &lt;8.0% – IDN reporting required</li> <li>• CARE.03_SUB_F – Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroids – NO IDN reporting required</li> <li>• CARE.03_SUB_G – Medication Management for People with Asthma – NO IDN reporting required</li> </ul>

## Sub-Measure: CARE.03\_Sub\_A – Controlling High Blood Pressure Component Flow

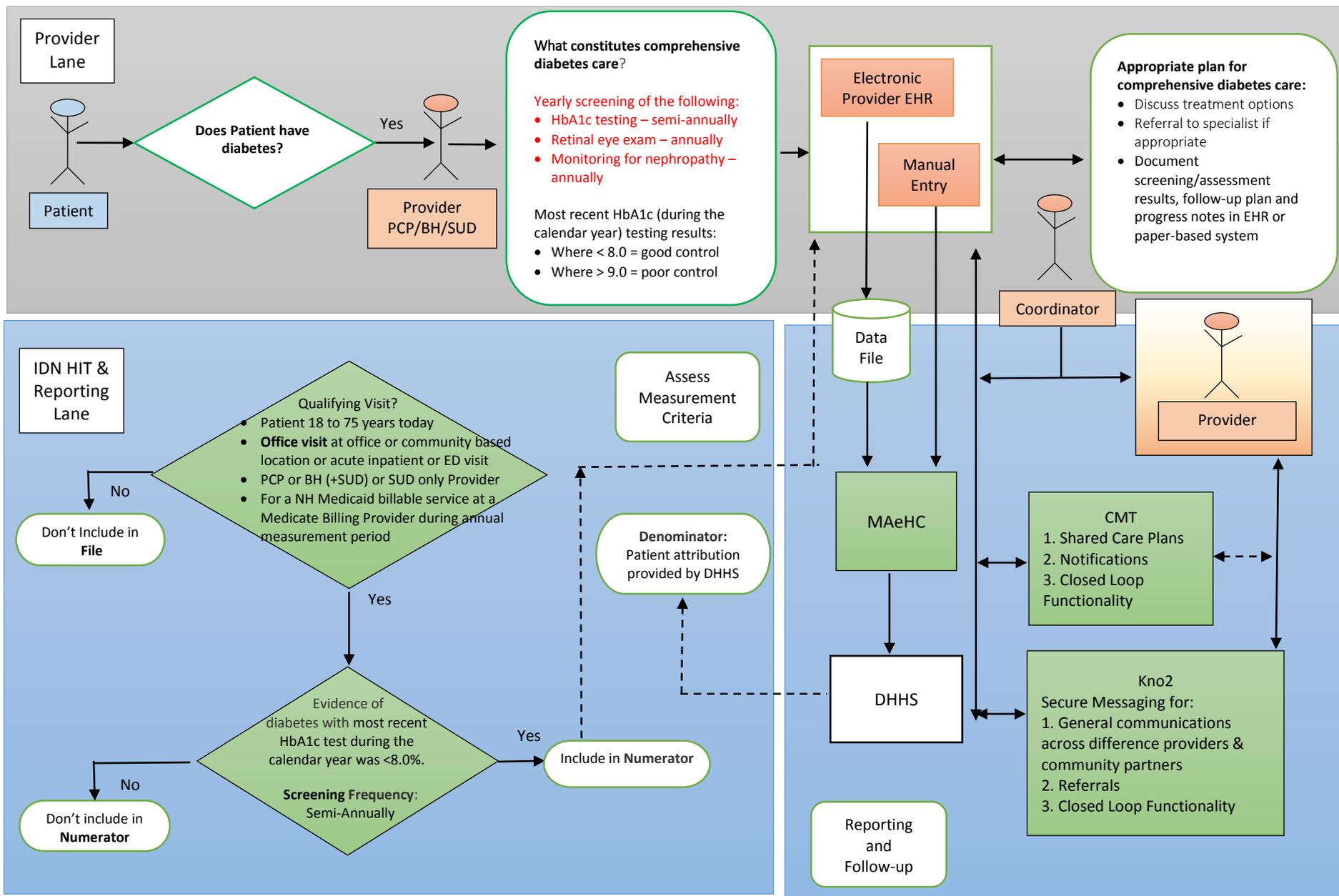


<b>Sub-Measure: CARE.03_Sub_C – Comprehensive Diabetes Care - HbA1c Control &lt;8.0%</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
Which IDN treatment providers are required to screen and provide comprehensive <b>diabetes care</b> and how often?	Required IDN Member Entities (Select ALL of the below): <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> <li>• IDN Partner Hospitals (diagnosed resulting from ED visit – acute or non-acute)</li> <li>• IDN Partner Nursing Facilities</li> </ul>		Intent of this HEDIS (CBP)* measure is to determine percent of Medicaid patients in the IDN’s attributed behavioral health population age 18 through 75 with a diagnosis of diabetes during the prior or current calendar year, whose most recent HbA1c test during the calendar year was <8.0%.  *Please refer to HEDIS Volume 2 Technical Specifications for Health Plan for granular details and detailed specifications on this measure
	Recommended Frequency:  HbA1c testing (as per 2018 HEDIS measure): <ul style="list-style-type: none"> <li>• HbA1c testing – <b>semi-annually</b> for patients who are meeting treatment goals (and who have stable glycemic control)</li> <li>• HbA1c testing – <b>every 3 months</b> for patients whose therapy has changed or who are not meeting glycemic goals (≥8.0 HbA1c)</li> <li>• Retinal eye exam - annually</li> <li>• Monitoring for nephropathy - annually</li> </ul>		
What constitutes diagnosis of <b>diabetes</b> by the IDN?	Recommended Guidelines:  Most recent HbA1c testing results: <ul style="list-style-type: none"> <li>• Where &lt; 8.0 = good control</li> <li>• Where &gt; 9.0 = poor control</li> </ul>	Eligibility (per DSRIP measures): <ul style="list-style-type: none"> <li>• Patients age 18 to 75 (at end of the calendar year) and continuously enrolled in Medicaid* for the entire calendar year, with only one gap of up to 45 days allowable in the attributed** IDN behavioral health population</li> <li>• With diabetes as indicated by:               <ul style="list-style-type: none"> <li>○ A diagnosis of diabetes resulting from an inpatient (acute or non-acute), outpatient, or</li> <li>○ emergency department visit two year prior to the end of the calendar year; or</li> <li>○ Dispensing of diabetes medication two year prior to the end of the calendar year.</li> </ul> </li> <li>• Seen for a NH Medicaid billable service office visit by an IDN primary care or behavioral health care provider during the recommended measurement period</li> </ul> *Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans including Premium Assisted Programs  Exclusions: <ul style="list-style-type: none"> <li>• Members In hospice; or</li> <li>• Members with gestational diabetes.</li> </ul>	**Attributed population is determined at the end of the calendar year by DHHS where DHHS will provide each IDN with a sample of members which will be used to determine a rate of members whose most recent HbA1c test result is <8.0%. The IDN will provide DHHS with the results of each member’s most recent HbA1c test results*** through electronic health records data. IDNs may gain credit for a numerator compliant reading provided by another IDN.  ***HbA1c test results will be identified through IDN electronic health record data. Diagnosis of diabetes will be identified using ICD-10 codes in claims and encounter data. Medication dispensing will be identified by National Drug Codes (NDC) in pharmacy claims and encounter data.

**Sub-Measure: CARE.03\_Sub\_C – Comprehensive Diabetes Care - HbA1c Control <8.0%  
(CONTINUED)**

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>What constitutes a <b>comprehensive diabetes care</b> plan by the IDN?</p>	<p>Recommended IDN policy for follow-up intervention (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Discuss treatment options</li> <li>• Referral to specialist if appropriate</li> </ul> <p>Recommended IDN follow-up documentation method (select ONE or MORE below):</p> <ul style="list-style-type: none"> <li>• Document screening/assessment results, intervention/follow-up plan and progress notes in: <ul style="list-style-type: none"> <li>○ organization’s Electronic Health Record (EHR) and/or</li> <li>○ paper-based system</li> </ul> </li> </ul>	<p>Per the IDN, a standardized closed loop referral workflow and protocol must be developed and implemented, if a referral is made.</p>	
<p>How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?</p>	<p>Recommended IDN options for capturing and reporting completion of blood pressure screening:</p> <ul style="list-style-type: none"> <li>• Electronic: provider attestation built into provider organization’s EHR <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>The summary score is calculated by DHHS by combining the numerators and denominators of four physical health HEDIS measures, one of which is CARE.03_SUB_C:</p> <p><b>CARE.03-C-NUM</b> (Numerator) - # of patients age 18 – 75 years old in the IDN’s attributed behavioral health population with a diagnosis of diabetes during the prior or current calendar year, whose most recent HbA1c test during the calendar year was &lt;8.0%</p> <p><b>CARE.03-C-DEN</b> (Denominator) patient attribution provided by DHHS</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	<p>The four physical health HEDIS measures are (note, identifiers Sub B, D, E are no longer used):</p> <ul style="list-style-type: none"> <li>• CARE.03_SUB_A – Controlling High Blood Pressure – IDN reporting required</li> <li>• CARE.03_SUB_C – HbA1c Control &lt;8.0% – IDN reporting required</li> <li>• CARE.03_SUB_F – Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroids – NO IDN reporting required</li> <li>• CARE.03_SUB_G – Medication Management for People with Asthma – NO IDN reporting required</li> </ul>

## Sub-Measure: CARE.03\_Sub\_C – Comprehensive Diabetes Care - HbA1c Control <8.0% Component Flow

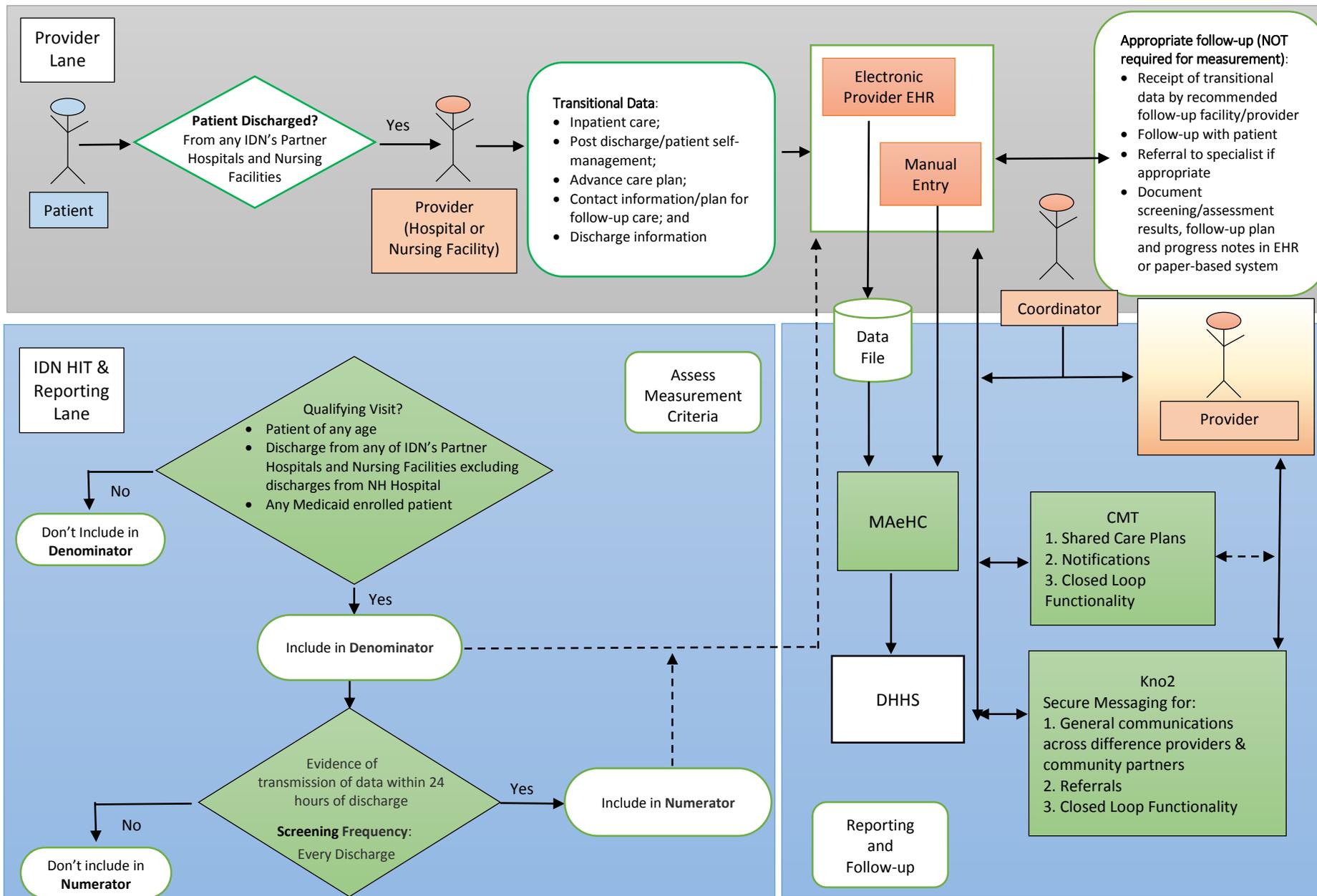


## HOSP\_INP.02 - Timely Transmission of Transitional Record After Hospital Discharge

Key IDN Considerations	IDN Recommendation/Policy	Protocols and Measurements	Notes
<p>Which IDN treatment providers are required to transmit transitional records after hospital discharge in a timely manner and how often?</p>	<p>Required IDN Member Entities (Select ALL of the below:</p> <ul style="list-style-type: none"> <li>• IDN Partner Hospitals</li> <li>• IDN Partner Nursing Facilities</li> </ul> <p>Required Frequency:</p> <ul style="list-style-type: none"> <li>• For every discharge</li> </ul>		
<p>What defines a transitional record and constitutes timely transmission and by the IDN?</p>	<p>Recommended Guidelines:</p> <p>A complete transition record is a set of data elements related to enrollee’s diagnosis, treatment, and care plan that is discussed with and provided to the enrollee in a printed or electronic format at each transition of care. The record should include:</p> <ul style="list-style-type: none"> <li>• Inpatient care;</li> <li>• Post discharge/patient self-management;</li> <li>• Advance care plan;</li> <li>• Contact information/plan for follow-up care; and</li> <li>• Discharge information</li> </ul> <p>Timeliness Requirement and to whom:</p> <ul style="list-style-type: none"> <li>• Within 24 hours of discharge</li> <li>• To any acute or non-acute facility, primary physician, or other health care professional</li> </ul>	<p>Eligibility (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Patients of all ages enrolled in Medicaid* with a discharge from an IDN’s partner hospital or nursing facility to another site of care, acute or non-acute</li> <li>• Partner hospital discharges to New Hampshire Hospital are included in this measure. However, discharges from NH Hospital are not included</li> </ul> <p>*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans including Premium Assisted Programs</p> <p>Attributed population will be provided by DHHS using claims and encounter data to the IDNs and will be a sample of Medicaid members who were discharged from facilities within the IDN. The IDN will verify that a completed transition record was transmitted for each member and will share that information with DHHS.</p> <p>Exclusions:</p> <p>Members who:</p> <ul style="list-style-type: none"> <li>• Died during the inpatient stay; and</li> <li>• Member who left against advice or discontinued care.</li> <li>• Discharges from non-IDN partner hospitals and nursing facilities and NH Hospital discharges are excluded.</li> </ul>	<p>The intent of the measure is to capture whether the inpatient facility sent a transition record including all required elements. Receipt of the transition record by the provider designated for follow-up care is not required. A record may be transmitted via secure fax, secure e-mail, or mutual access to an electronic health record system. The time and method of transmission should be documented to assess whether transmission was timely.</p>

<b>HOSP_INP.02 - Timely Transmission of Transitional Record After Hospital Discharge (CONTINUED)</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Protocols and Measurements</b>	<b>Notes</b>
How will this measure be reported to MAeHC to ensure it is included as a numerator during the reporting period?	<p>Recommended IDN options for capturing and reporting completion of blood pressure screening:</p> <ul style="list-style-type: none"> <li>• Electronic: discharge data and time of transmittal built into provider organization's EHR <ul style="list-style-type: none"> <li>○ Treatment provider to deliver electronic file monthly (minimum) to MAeHC</li> </ul> </li> <li>• Manual to electronic: provider attestation documented in notes for care coordinator/case manager <ul style="list-style-type: none"> <li>○ Care coordinator/case manager to manually input into MAeHC data portal, indicating provider name and date of appropriate follow-up for potential depression screening</li> </ul> </li> </ul>	<p>Measurements required (per DSRIP measures):</p> <p>Percent of discharges at the IDN's Partner Hospitals and Nursing Facilities for Medicaid patients of any age to a home or any other site of care during the calendar year, for which a complete transition record was transmitted to the provider (acute or non-acute facility, primary physician, or other health care professional) designated for follow-up care within 24 hours of discharge:</p> <p><b>HOSP_INP.02-NUM</b> (Numerator) - # of patients discharged from inpatient care and transitional data transmitted within 24 hours of discharge  <b>HOSP_INP.02-DEN</b> (Denominator) - # of the eligible population during the reporting period as provided by DHHS  <b>HOSP_INP.02-RATE</b> (Percent) -  Numerator/Denominator*100 (percent rounded to 1 decimal place)</p> <p>Frequency of reporting (per DSRIP measures):</p> <ul style="list-style-type: none"> <li>• Annually</li> </ul>	

## HOSP\_INP.02 - Timely Transmission of Transitional Record After Hospital Discharge Component Flow



# IDN-3 Closed Loop Referral

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GUIDELINES AND RECOMMENDATIONS

V1.3

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Delivery System Reform Incentive Payment (DSRIP)  
Integrated Delivery Network (IDN) 3

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## Change Log

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Date	Change	Version
08/03/2018	Document Created	V1.0
09/2018	Added new sections	V1.1
12/2018	Document updated based Clinical Committee initial feedback	V1.2
01/02/2019	Updates based on review feedback <ul style="list-style-type: none"><li>• Moved Glossary to end of document</li><li>• Section 2.2.1.4 b. to add that updates can happen automatically or in a manual manner</li><li>• Section 2.2.5.3 b. added language that the receiving provider should try to address the barriers, otherwise, reach out to the referring provider...</li></ul>	V1.3

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## Introduction

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The goal of this guide is to provide minimum recommended guidelines for implementing referrals in a coordinated or integrated care system. The guide provides a minimum set of competencies, tools and key considerations to achieving closed loop referral among participating providers or practices. IDN3 encourages providers/practices to discuss all referral options keeping the minimum recommended guidelines. Patient participation is a key factor in the success of any referral process. Creating a partnership with the patient will encourage their participation in their own recovery, enhance self-management of their illness, including use of personally defined outcomes and their support to broader recovery goals in their care plan. Nothing in this guide is intended to interfere with Providers/Practices relationship with their patients.

Referrals are an integral part of an integrated health care system as most organizations cannot address all aspects of a beneficiaries' needs. Many times, however, a referral is given but no action comes out of it. A report published in 2017 by the Institute for Healthcare Improvement and the National Patient Safety Foundation out of Boston, MA, notes that of the more than 100 million subspecialist referrals requested each year in the United States, only half are completed. To ensure better outcomes, IDN 3 is committed to encourage a closed loop referral process to be established by providers.

Referrals can be made via paper, phone or electronically. IDN3 has budgeted to support each IDN member to contract directly with a direct secure messaging (DSM) vendor such as Kno2 to support secure information sharing across providers. This will serve as a tool to support the workforce in conducting closed loop referrals. The following are one or more goals/principals of IDN 3's closed loop referral process:

- Improving service to patients and their access to care which is timely, effective and safe
- Improving on and streamlining provider to provider referral process and care coordination
- Improving effective communication and information transfer between mental health and primary care providers in order to provide optimal integrated care.
- Establishing accountability
- Using evidence-based practices to improve both patient and community health
- Making progress in CIHS' Standard Six-Level Framework for Levels of Integrated Healthcare model towards a high functioning integrated health system of care with a goal to provide patients/clients access to the "right care, at the right time, in the right place."

# 1. IHI & NPSF best practices for closed loop referrals

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 EHRs for referrals;
- Ensure seamless information flow by addressing interoperability issues; and
- Measure the effectiveness and safety of the referral process.

Out of the above, a nine-step, closed-loop EHR referral process *example* was identified that follows this sequence:

1. The primary care physician orders a referral.
2. The primary care physician or a designated staff person communicates the referral to the subspecialist.
3. The referral is reviewed and authorized.
4. An appointment is scheduled.
5. The consult appointment occurs.
6. The subspecialist communicates the plan to the patient.
7. The subspecialist communicates the plan to the primary care physician.
8. The primary care physician acknowledges receipt of information from the subspecialist.
9. The primary care physician communicates the plan to the patient and the family.

## 1.1 IDN 3 Recommended Best Practices

The IDN 3 Provider Liaison will work with organizations 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:

- Reason for referral clearly stated
- Referral sent to specialty care in a timely manner with supporting information included
- Specialist response addresses the reason for referral
- Receiving provider reports back to referring provider within 7 days after patient is seen
- PCP, specialist, and patient/family are satisfied
- EHR support for referral process is maximized, documenting outcomes of the referral (no show, waived; attended; follow up action executed) either manually or electronically in an EHR system
- Understanding the "no show" scenarios
- Reminder systems can be utilized for better outcomes:

- ADT alert system could be utilized to notify the receiving provider.
- reminder system to remind receiving provider
- reminder system to remind patient for scheduled appointment (patient appointment reminder plan; or telehealth reminder

IDN 3 will follow these guidelines for this document for its policies related to closed loop procedures and workflows for partners who will participate in this referral process.

## 1.2 Roles for Closed Loop Referral Process

Integrated care requires providers and clinicians (primary care and behavioral health) to work together around the needs of a patient, their families and their communities. Determine who is responsible for facilitating the closed loop referral process which includes:

- connecting the patient to the referral services they need
- follow up
- care coordination for multiple pathways

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### 1.3 Closed Loop Referral Guidelines Table

Key IDN Considerations	IDN Recommendation/Policy	Tools	Notes
Which IDN treatment providers are expected to participate in closed loop referral process?	Minimally Required: <ul style="list-style-type: none"> <li>• Primary Care Billable Providers</li> <li>• Mental Health Care Billable Providers</li> <li>• Substance Use Disorder (SUD) Billable providers</li> </ul> Preferably all IDN 3 Providers including Community Based Service Providers	<ul style="list-style-type: none"> <li>• <b>Kno2</b> as the IDN 3 recommended Direct Secure Messaging Tool used both for secure messaging and for electronic closed loop referral system</li> <li>• It is desired 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</li> </ul>	
What? <ul style="list-style-type: none"> <li>• Referral to treatment providers or community based organizations as assessed need</li> <li>• Coordination among case managers (internal and external to IDN)</li> <li>• Procedures to providing prescriptions and refills</li> <li>• Procedures for informing patients of laboratory outcomes</li> </ul>	Considerations and Recommendations: <ul style="list-style-type: none"> <li>• Document what information is provided to treatment providers, what is available to community based organizations and how privacy will be protected</li> <li>• Define set of clinical and other information critical to diagnosis, treatment and management of care.</li> </ul>		
What constitutes "closed"	Recommendation: <ul style="list-style-type: none"> <li>• Minimally, close once one or more of the following is received by the referring provider from the receiving provider within 1 week of the appointment:               <ul style="list-style-type: none"> <li>○ "Confirmation of attendance" and/or</li> <li>○ "Patient engaged in treatment" and/or</li> <li>○ "Needs further referral"</li> <li>○ "Not eligible for state supported services"</li> </ul> </li> <li>• ideally, close with attached outcomes &amp; follow-up with referring provider and patient with input into a shared care plan if available and appropriate</li> </ul>		

<b>Closed Loop Referral Guidelines Table (CONTINUED)</b>			
<b>Key IDN Considerations</b>	<b>IDN Recommendation/Policy</b>	<b>Tools</b>	<b>Notes</b>
<p>What is considered timely communication by the IDN? Types of referrals:</p> <ul style="list-style-type: none"> <li>• <b>Urgent Referral</b> – referrals that require the patient/client to be seen immediately</li> <li>• <b>Priority Referral</b> – Referrals that require the patient to be seen within 3-14 days (from referral sent to patient seen)</li> <li>• <b>Routine Referral</b> – referrals that require the patient/client to have an appointment scheduled within 14 days – not seen</li> <li>• <b>Long Term Referrals</b> – Referral which may take greater than 14 days to schedule</li> </ul> <p><b>Priority/Routine Patient/Client Preference Referrals</b> – referrals with appointments that are not in the specified time period due to patient preference</p>	<p>Time Recommendations for documenting Closed Loop completion:</p> <ul style="list-style-type: none"> <li>• Referring units documenting outcomes of the referral (no show, waived; attended; follow up action executed) either manually or electronically in an EHR system within 72 hours after receiving provider/patient interaction</li> <li>• Referring provider to follow up with patient within 7 days after patient is marked as no show or waived)</li> </ul>	<p>Potential functionality via tools</p> <ul style="list-style-type: none"> <li>• Receiving Provider: alert System to notify the receiving provider including a REMINDER system - (CMT)</li> </ul> <p>Patient: REMINDER system for scheduled appointments (Patient Appointment Reminder Plan or Telehealth Reminder)?</p>	
<p>What are some privacy considerations?</p>	<p>Recommended protocols:</p> <ul style="list-style-type: none"> <li>• Ensure conversation with Patient/Client on Information Sharing and Confidentiality</li> <li>• Intake procedures that include patient consent to confidentially share information among providers</li> <li>• Identify what information is provided to treatment providers, what is available to community based organizations and how privacy will be protected</li> <li>• The patient has a right to refuse providers outside the practice access to their medical information, thus it is imperative to acquire patient consent</li> </ul>		
<p>What is considered appropriate closed loop follow-up practices?</p>	<p>Considerations/Recommendations:</p> <ul style="list-style-type: none"> <li>• Follow up with Patient regarding outcomes if appropriate</li> <li>• Safe transitions from institutional settings back to primary care, behavioral health and social support service providers</li> <li>• For patients with significant behavioral health conditions or chronic conditions, regularly scheduled (minimum monthly) core team (plus other providers as needed) case conferences and/or use of shared care plans</li> <li>• Define process to document EMR outcomes of the referral (no show, waived; attended; follow up action executed)</li> </ul>		

## 2. Workflows

### 2.1 General guidelines and considerations which apply to all referral scenarios:

#### 2.1.1 Referral Types

Based on urgency of care required, PCP marks the referral as:

- a. Urgent Referral – Referrals that require the patient/client to be seen immediately.
- b. Priority Referral – Referrals that require the patient to be seen within 3-14 days (from referral sent to patient seen)
- c. Routine Referral – Referrals that require the patient/client to have an appointment scheduled within 14 days – not seen.
- d. Long Term Referral – Referral which may take greater than 14 days to schedule
- e. Priority/Routine Patient/Client Preference Referrals – referrals with appointments that are not in the specified time period due to patient preference

#### 2.1.2 Sending Referral

The referral is sent to the receiving provider by the referring provider via:

- a. Paper
- b. Phone
- c. Fax
- d. Direct Secure Message (Kno2)
- e. Electronic Health Record (EHR) System

#### 2.1.3 Referring provider sends Summary of Care Record with referral that includes:

##### 2.1.3.1 Minimal Considerations

- Patient information as needed
- Reason for Referral – Clinical Issue/Information
- Current problem list
- Current medication list
- Current allergy list
- Referral Urgency

##### 2.1.3.2 Additional Considerations

- Plan of Care field (Patient/client centered goals and instructions)
- Care team (other providers)

### 2.1.4 No Shows

- a. *The Receiving Provider:* If the patient/client doesn't show up as per the scheduled appointment, the receiving provider marks it as a "No Show" and notifies the referring provider
- b. *The Referring Provider:* tries to contact patient up to 3 times to discuss next steps and any barriers to re-scheduling and completing the appointment process; understanding patient barriers is key to understanding a "No Show" scenario.
- c. The referral process can be closed if no progress can be made.
- d. If the patient has a case manager/coordinator, they should be notified.

### 2.1.5 Delayed referral timing:

Develop workflows/procedures for delayed referral timing due to the following issues:

- a. Delayed Priority Referral
  - Provider Availability Delays
  - Patient/client preference
- b. Delayed Routine Referral
  - Provider Availability Delays
  - Patient/client preference

## 2.2 Referral Scenarios

There are basically three ways a referral is scheduled:

1. The referring provider schedules the appointment
  - a. Scenario documented with flow is where referring provider schedules the appointment at the time of the visit
  - b. Other scenarios to consider are where the referring provider schedules the appointment for the patient at a later date and informs the patient of the appointment date/time.
2. The receiving provider schedules the appointment
3. The patient is responsible for scheduling the appointment

### 2.2.1 The referring provider schedules the appointment (preferred)

The following are workflow considerations for the scenario where the referring provider is scheduling the appointment.

#### 2.2.1.1 Appointment Scheduling –

- a. *The Referring Provider:* The patient/client is scheduled for an appointment with the receiving provider based on referral urgency and patient/client preference at the time of the visit.

#### 2.2.1.2 Referral Provider Sends the Referral via one of the listed mechanisms

#### 2.2.1.3 Referring provider sends minimal summary of care referral information along with Referral Type

#### 2.2.1.4 Closing the Loop

##### a. *The Receiving Provider:*

- Once the patient/client is seen by the receiving provider, the receiving provider sends one or more of 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”
- If shared care plan (SCP) available, ideally, the receiving provider also updates outcomes & follow-up plan in SCP

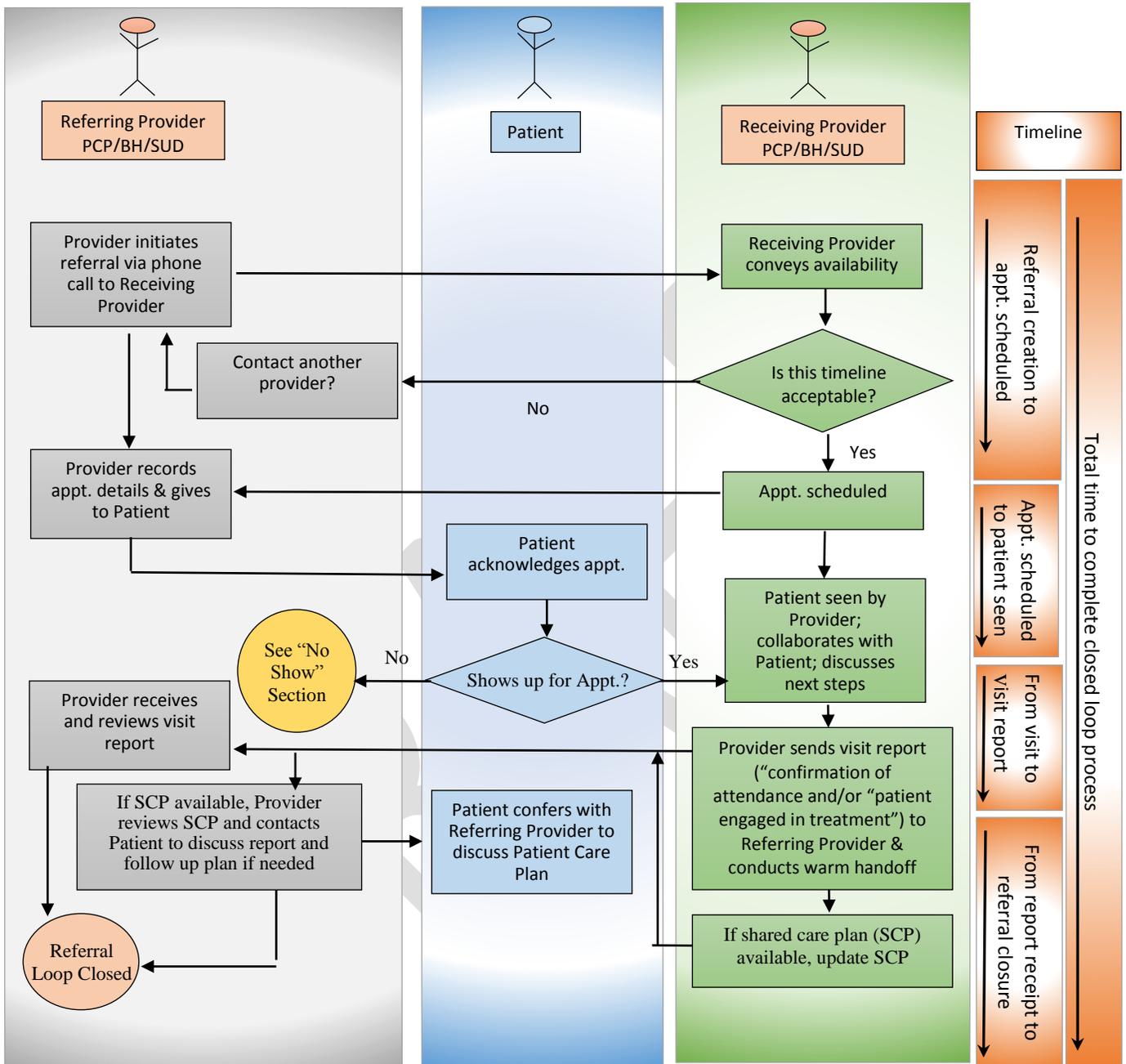
##### b. *The Referring Provider:*

- Documents outcome provided by receiving provider either manually or electronically in an EHR system whether that is automated or needs some manual interventions.
- If shared care plan (SCP) available, review updates to SCP & follow-up with patient if needed

#### 2.2.1.5 Closing the Referral

- a. Once the referral action is complete as per the closed loop completion criteria, the referral can be closed
- b. Long Term referrals may take a significant amount of time to complete the process and may need case management or care coordination. These types may need provider specific work flows and guidelines.

## 2.2.2 Referring Provider Schedules Appointment Pictorial Flow



### 2.2.3 The receiving provider schedules the appointment

The following are workflow considerations for the scenario where the receiving provider is scheduling the appointment.

#### 2.2.3.1 Referral Provider Sends the Referral

#### 2.2.3.2 Referring provider sends Summary of Care Record along with Referral Type with referral

#### 2.2.3.3 Appointment Scheduling

- a. *The Receiving Provider:* contacts patient/client to schedule an appointment based on referral urgency and patient/client preference.
- b. *The Receiving Provider:* If the patient is unreachable, retry 2-3 times. If still unreachable or unable to schedule required appointment, notify referring provider as such.
- c. *The Referring Provider:* tries to contact patient to discuss next steps and any barriers to scheduling and completing the appointment process.

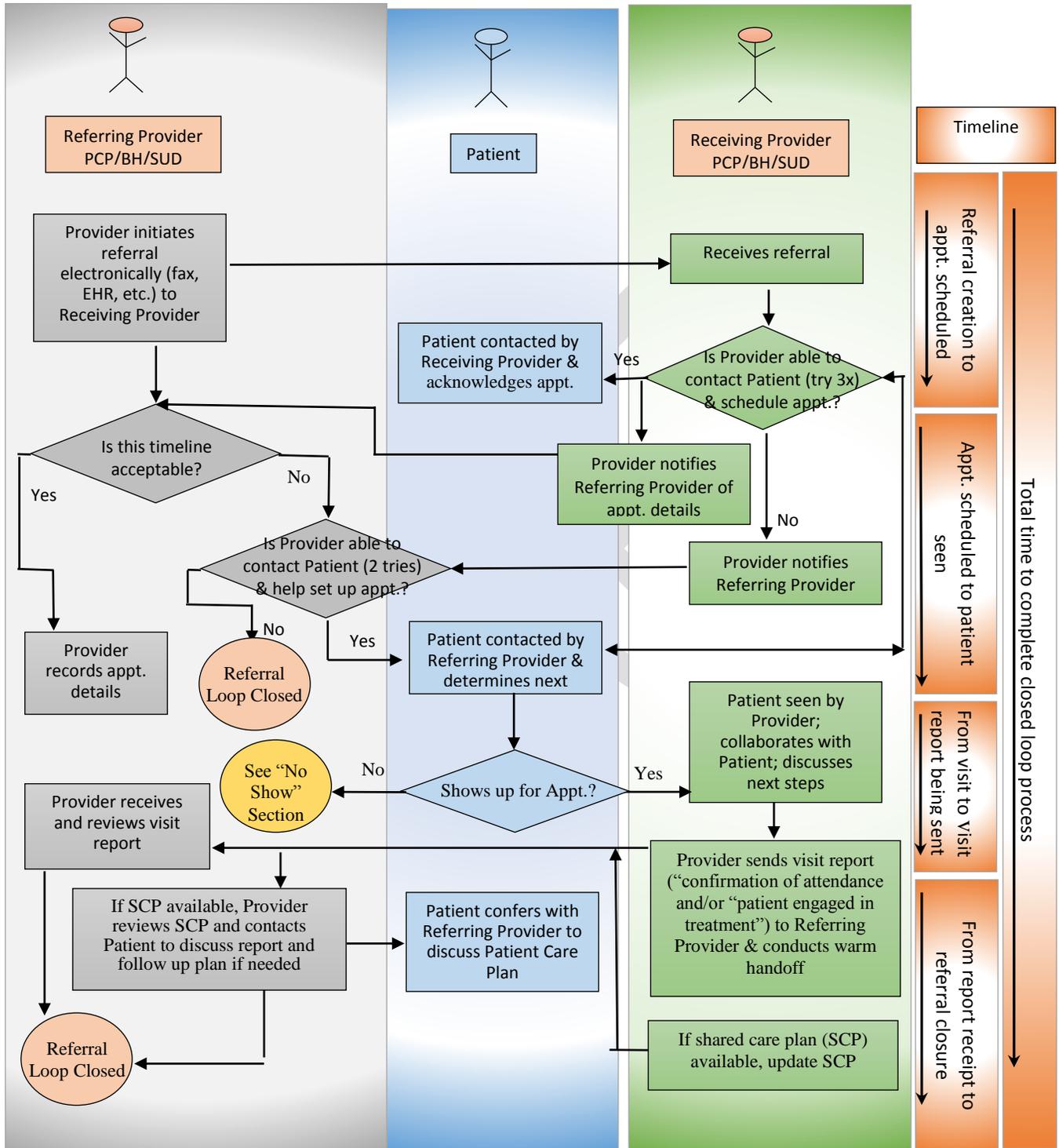
#### 2.2.3.4 Closing the Loop

- a. *The Receiving Provider:*
  - Once the patient/client is seen by the receiving provider, the receiving provider sends one or more of 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”.
  - If shared care plan (SCP) available, ideally, the receiving provider also updates outcomes & follow-up plan in SCP
- b. *The Referring Provider:*
  - Documents outcome provided by receiving provider either manually or electronically in an EHR system
  - If shared care plan (SCP) available, review updates to SCP & follow-up with patient if needed

#### 2.2.3.5 Closing the Referral

- a. Once the referral action is complete as per the closed loop completion criteria, the referral can be closed
- b. Long Term referrals may take a significant amount of time to complete the process and may need case management or care coordination. These types may need provider specific work flows and guidelines.

## 2.2.4 Receiving Provider Schedules Appointment Pictorial Flow



## 2.2.5 The patient is responsible for scheduling the appointment

The following are workflow considerations for the scenario where the patient is scheduling the appointment.

### 2.2.5.1 Referral Provider Sends the Referral

### 2.2.5.2 Referring provider sends Summary of Care Record along with Referral Type with referral

### 2.2.5.3 Appointment Scheduling

- a. *The Patient/Client*: contacts receiving provider to schedule an appointment based on referral urgency and patient/client preference.
- b. *The Receiving Provider*: If the appointment is unable to be made due to scheduling barriers, the receiving provider should try to address patient barriers if possible, otherwise, should reach out to the referring provider to discuss next steps.
- c. *The referring provider*: tries to contact patient to discuss next steps and any barriers to scheduling and completing the appointment process.

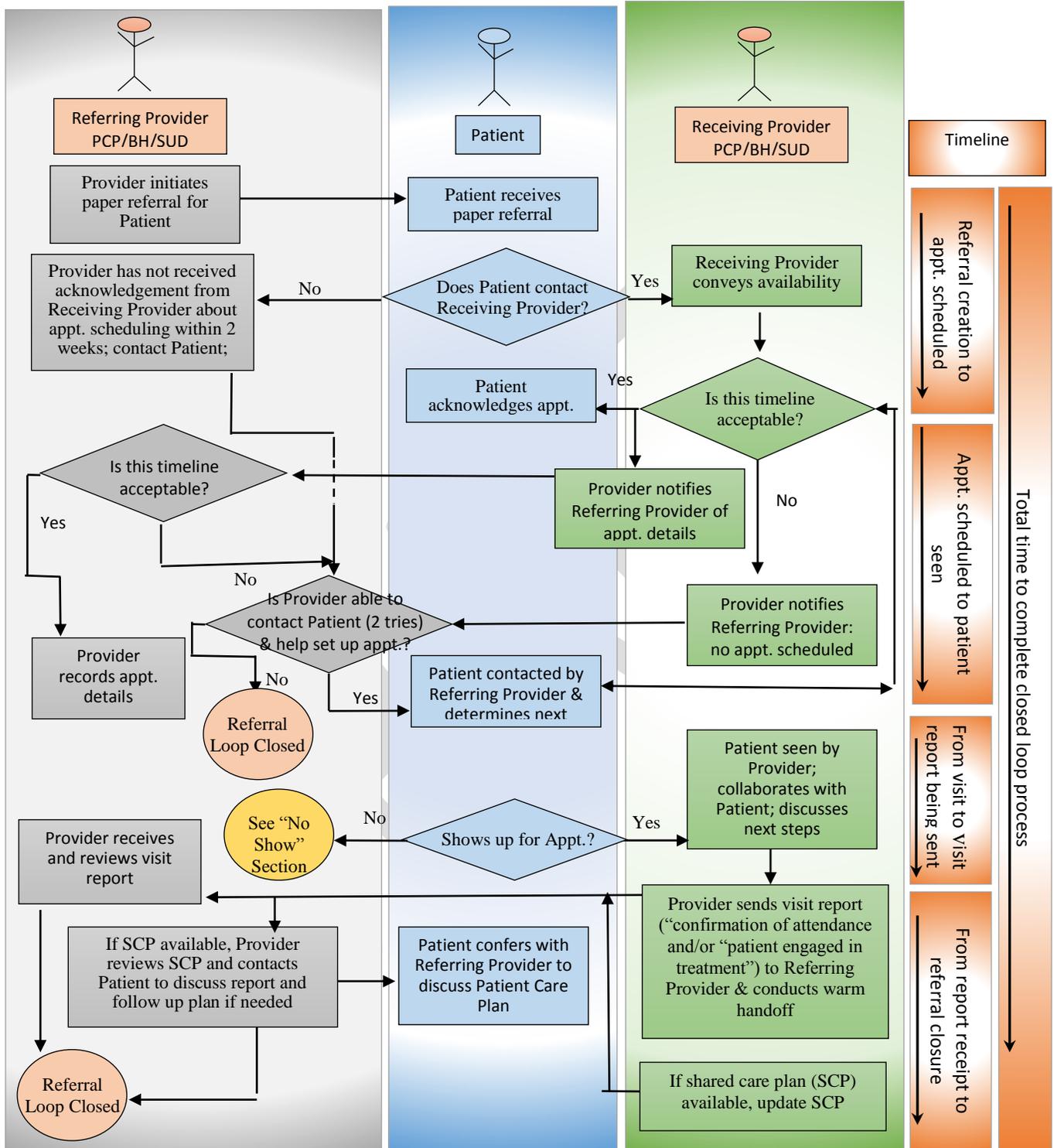
### 2.2.5.4 Closing the Loop

- a. *The Receiving Provider*:
  - Once the patient/client is seen by the receiving provider, the receiving provider sends one or more of 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”.
  - If shared care plan (SCP) available, ideally, the receiving provider also updates outcomes & follow-up plan in SCP
- b. *The Referring Provider*:
  - Documents outcome provided by receiving provider either manually or electronically in an EHR system
  - If shared care plan (SCP) available, review updates to SCP & follow-up with patient if needed

### 2.2.5.5 Closing the Referral

- a. Once the referral action is complete as per the closed loop completion criteria, the referral can be closed
- b. Long Term referrals may take a significant amount of time to complete the process and may need case management or care coordination. These types may need provider specific work flows and guidelines.

## 2.2.6 Patient Schedules Appointment



### 3. IDN 3 Approved HIT Vendors for DSM, ENS, and SCPs

While it is important to have consistent workflows, HIT can help to aid and streamline some of the critical steps in coordinated care and closed loop referral process. The following vendors have been approved by IDN IT/Data Governance Committee for Direct Secure Messaging and Event Notification (ENS)/Shared Care Plans (SCPs). ENS/SCPs will be discussed in more detail within the context of Multidisciplinary Case Management.

#### 3.1 Kno2, LLC

Kno2 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

#### 3.2 Collective Medical Technologies (CMT)

The CMT 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 CMT 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) & Pre-Manage (for ambulatory settings)

### 4. Patient Confidentiality Considerations

The HIPAA Privacy Rule permits clinicians and IDN3 member entities to exchange Protected Health Information (PHI), with certain protections and limits, for activities involving Treatment, Payment, and Operations. An individual's authorization for Release of Information (ROI) is not required when PHI is being exchanged with IDN3 network clinicians, providers or other entities for the purposes of Treatment, Payment or Health Care Operations as enumerated in HIPAA (and consistent with applicable state and Federal Law).

In the B1 section of the New Hampshire Building Capacity for Transformation 1115(a) Special Terms and Conditions, CMS outlines information sharing requirements for coordinated care practice designation which stipulates the following:

- Documented workflows that incorporate a communication plan inclusive of protocols related to what information is provided to treatment providers, what is available to community based organizations and how privacy will be protected. Closed-loop referral capabilities (electronic or non-electronic)
- Requires “Intake procedures that include systematically solicit patient consent to confidentially share information among providers”
- 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.

## 5. Mutual Agreements for Referral Management

A critical element of effective referral management is making certain that referring and receiving providers agree on the purpose of the intervention and referral action and the roles that each will play in providing care. The lead agency (host of integrated care coordinating hub) need to initiate conversations with their partners both primary care, specialist practices, BH and social service organizations to discuss preferences, roles and expectations including:

- Types of patients targeted; referred for services. Many practices/specialist and/or community agencies have developed criteria for the patients they prefer to see.
- Information provided at the time of referral.
- Notifications from hospital for ED visits or hospitalizations.
- Screenings/assessments or testing to be completed prior to referral
- Post-referral/consultation care expectations.
- Post ED or hospitalizations care expectations
- Specialist to specialist referrals. Many PCPs do not want specialists to refer their patients to other specialist without consulting with the PCP or the designated Care Coordinator.

These conversations can result in operational agreements that can be codified in writing or programmed into electronic referral systems. Such agreements may to be critical to reducing unnecessary referrals, avoiding duplicated assessments, and ensuring optimal post-referral or post-hospital care.

## 6. Measurements

It is important to measure improvements and successes. Therefore, defining specific, measurable outcomes and objectives are critical to determine where things are working and where improvements are needed as well as identifying resource gaps within the community. Some examples of potential measurements:

- % decrease in # of total days from referral created to referral closed
- % decrease in # of total days from scheduled appointment to Patient seen
- % decrease in # of open referrals
- % increase in number of closed referrals
- % of complete summary of care records sent after referral visit completion
- Referring Provider, receiving provider and patient satisfaction with the referral process.
- Metrics around “no show” scenarios – was it because of transportation, work schedule?

Use data to assess team progress and performance at least every month, ideally every week.

- Are we accomplishing the work we set out to do as a care team?
- Are we meeting our goals and objectives?
- Where are our opportunities for improvement? What will we test to see if it results in an improvement?

## Glossary

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**Behavioral Health** – Behavioral health includes mental health services as well as Substance Use Disorder (SUD) services.

**DHHS** – Department of Health and Human Services.

**Direct Secure Messaging (DSM)** – The ability to transmit protected health information (PHI) between providers which includes secure sharing of documents related to information sharing and care coordination.

**DSRIP** - Delivery System Reform Incentive Payment is a vehicle for states to improve health outcomes and population health by reforming the health care delivery system to be more effective in addressing both physical and behavior health for the Medicaid population.

**Electronic health record (EHR) or other electronic tracking system** – For the purposes of this document, an Electronic Health Record or other electronic tracking system, includes a treatment provider’s medical record system (e.g., Epic, GE Centricity), a platform that allows IDN member entities to store or query data, or the IDN’s reporting service, MAeHC.

**Event Notification Service (ENS)** – Allows providers to receive notifications through an automated service that provides timely alert messages when patients are discharged from a hospital or emergency department.

**HIT** - Healthcare Information Technologies

**Health Insurance Portability and Accountability Act (HIPAA)** - HIPAA Law provides a uniform, basic level of security and privacy throughout the country for patients passed by Congress in 1996. The HIPAA Privacy regulations require health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. Furthermore, only the minimum health information necessary to conduct business is to be used or shared. Please refer to the following: HIPAA [Privacy Rule](#) and the HIPAA [Security Rule](#).

**Integrated Delivery Network (IDN)** - The provider networks that form regional coalitions and collectively pool funds as a single region, based upon attributed population.

**Institute for Healthcare Improvement and National Patient Safety Foundation (IHI and NPSF)** – These two organizations both out of the Boston, MA area, joined forces to become one organization as of May 1, 2017. NPSF is known for its thought leadership and research on patient safety, while IHI is a considered a leader in redesigning healthcare to be safer and more efficient. This document references a specific study by this organization, "Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era", published in 2017.

**IDN’s Medicaid Billing Provider** – A provider who accepts NH Medicaid as part of the IDN.

**Medicaid Population** – For the purpose of DSRIP demonstration, the Medicaid population includes those NH residents enrolled in a Medicaid Managed Organization (NH Healthy Families or WellSense), a Qualified Health Plan as part of NH’s premium assistance program (Ambetter commercial plan with PAP indicator, Anthem commercial plan with PAP in group name, Harvard Pilgrim commercial plan with PAP in group name, or Minuteman commercial plan with PAP in group name, which is plan sunsetting 12/31/17) or a Medicaid Fee for Service (FFS) plan, regardless of whether the person also has coverage from another source (e.g., Medicare, commercial insurance).

**Myers and Stauffer, LC (MSLC)** – Myers and Stauffer provides professional accounting, consulting, data management and analysis services to state and federal agencies managing government-sponsored health care programs. They have been contracted by NH DHHS to facilitate the sharing of best practices and lessons learned to support Integrated Delivery Network (IDN) project implementation and attainment of the state’s overall waiver goals.

**Office and Community Based Visit** – Preventive, medical or behavioral health encounter at the following locations: school, homeless shelter, office, home, assisted living facility, group home, mobile unit, temporary lodging, walk-in retail clinic, place of employment, independent clinic, federally qualified health center, mental health center, non-residential substance abuse treatment facility, comprehensive outpatient rehabilitation facility, public health clinic, and rural health clinic.

**PCP** - Primary Care Provider

**Protected Health Information (PHI)** - Protected health information is the term given to health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations and payment for healthcare services which can be linked to a specific individual such as name or date of birth.

**Release of Information (ROI)** – An authorization from the patient that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual

**Shared Care Plan (SCP)** – An electronic tool for information sharing between providers for case management and treatment plan implementation across a Multi-Disciplinary Core Team.

**Special Terms and Conditions (STC’s)** - Special Terms and Conditions enable the State of NH (and the IDNs) to operate the demonstration, setting forth the nature, character, and extent of federal involvement in the demonstration and are approved through December 31, 2020

# IDN-3 Adult CCSA Overview and Pathways

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GUIDELINES AND RECOMMENDATIONS

V1.1



Delivery System Reform Incentive Payment (DSRIP)  
Integrated Delivery Network (IDN) 3

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## Change Log

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<b>Date</b>	<b>Change</b>	<b>Version</b>
08/03/18	Document Created	V1.0
09/18	Added new sections	V1.1

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# Introduction

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New Hampshire's *Building Capacity for Transformation* Section 1115 demonstration aims to transform the way care is delivered to some of the most medically complex and costly Medicaid beneficiaries in the state as well as to children, youth and adults with undiagnosed or untreated behavioral health conditions. This will be accomplished through transforming the behavioral health delivery system through:

- Integrating physical and behavioral health to better address the full range of beneficiaries' needs and input to development of patient shared care plans; the goal is to have a shared collaborative approach between primary care and mental health care where the sense is that these are OUR patients.
- Expanding provider capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

## 1. The Comprehensive Core Standard Assessment (CCSA)

Use of a Comprehensive Core Standard Assessment process (conducted at a minimum annually) is the basis for an individualized care plan used by the care team to guide the treatment and management of the target sub-population (IDN attributed Medicaid beneficiaries). The CCSA is intended to be a standardized screening process that integrates medical, behavioral and social needs and results in the identification of needs with appropriate referrals and linkages. Standardization results from the screening of a core set of domain areas. These domains include the following:

1. Demographic
2. Medical
3. Education
4. Employment and Entitlement
5. Housing
6. Functional status (activities of daily living, instrumental activities of daily living, cognitive functioning including transportation)
7. Family and Support Services
8. Legal
9. Depression screening
10. Substance Use (including Tobacco Use)
11. Risk assessment (including Suicide Risk and Intimate Partner Violence)
12. Pediatric developmental screening

The IDN-3 Clinical Governance Committee approved the IDN Comprehensive Core Standardized Assessment (CCSA) tool to address each domain defined in the DHHS Special Terms and Conditions (STCs). Below is the crosswalk of IDN 3 CCSA tool to each domain, recommendations for positive outcomes and potential associated pathways.

### 1.1 DEMOGRAPHICS

It was decided at Clinical Committee meeting that other demographics such as age, gender, race, ethnicity, are already being captured as part of provider intake forms or within EHR systems as an existing patient, thus would be duplication if also captured as part of the CCSA tool.

### 1.2 Recommended action:

- a. Capturing patient name and date of birth (DOB).
- b. Determine if patient needs assistance with language or with filling out the form - use provider current policy & procedure

### 1.3 MEDICAL

The purpose of this domain is to reinforce the benefits of routine physical health assessments and care for the patient and to determine if emergency department visits can be reduced by providing better continuum of care. Some patients may not know that annual physicals and well care visits are at no cost to the patient and can:

- help patients understand their current health status and identify actions to improve their health
- improve relationships with their provider by creating an environment for stimulating open dialog and identify areas which are of concern to the patient
- help address and monitor chronic conditions more effectively to reduce or avoid emergency care
- help identify issues requiring referrals to other providers or community services
- have many other positive outcomes

<b>1. Question Origin:</b> PRAPARE tool (slightly modified question)	Yes	No
Do you see your doctor at least once a year for a physical or well care visit?	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin:</b> DHHS Feedback – intent is to start conversation on use of ED	Yes	No
Have you had an emergency room (ED) visit in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>

#### 1.3.1 Recommended action for negative response – Question 1:

- a. Inquire why. Are they using ED or immediate care instead?
- b. Ask if they are aware that well care visits are covered 100% if patient has insurance
- c. Facilitate connection with primary care provider for an annual wellness visit
- d. Refer to [Medical Referral Pathways](#).

- 1.3.2 Recommended action for positive response – Question 2:
- Assess reason for ED visit
  - Review patient history for reason for repeated ED visit
  - Provide educational resources on community crisis prevention
  - Evaluate for eligibility to access available community resources and referral to more intensive BH treatment services.
  - Refer to [Medical Referral Pathways](#).

## 1.4 EDUCATION

This domain’s focus is to identify and understand specific knowledge and skill set the patient has or will need to have to make care decisions, participate in their care, and continue care at home as well as how education barriers might impact their financial well-being. This provides an opportunity to partner with the patient to explore what types of barriers may be present which prevents the patient from receiving further education and/or establishing/reviewing educational goals and possible pathways. Some patient variables to consider during assessment are:

- their literacy, educational level, and language;
- emotional barriers and motivations;
- physical and cognitive limitations; and
- understanding the patient’s preferred way of learning

<b>1. Question Origin:</b> DHHS Feedback – intent is to start conversation about education, especially for those who are school age & not attending school		Yes	No
Are you currently attending school?		<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin:</b> PRAPARE tool (slightly modified answer choices)	Middle school	High school diploma or equivalent	More than high school
What is the highest level of school you have finished?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1.4.1 Recommended action for negative response – Question 1:
- If minor, inquire why they are not attending school at the expected grade level.
  - If not minor, does this hinder their well-being?
  - Refer to [Education Pathways](#).

- 1.4.2 Recommended action – Question 2:
- If not minor & education is not at expected level, does this hinder their well-being & ability to make proper health decisions or have impacts to their ADLS; if so, inquire if patient is interested and/or able to further their education
  - Explore and assess needs and literacy support systems; refer to appropriate organization in education pathways
  - Refer to [Education Pathways](#).

## 1.5 EMPLOYMENT AND ENTITLEMENT

This domain is to help the provider determine if the patient has financial barriers either for having access to their basic needs or for continued growth and potential restrictions to access to the needed health care. This can be an opportunity to partner with client to provide assistance in:

- resume development, cover letter writing and/or filling out application(s)
- preparing for appointments or job interviews (e.g. childcare, transportation, clothing needs)
- contacting or referring to employment resources
- getting health insurance

1. <b>Question Origin:</b> <i>PRAPARE tool (slightly modified answer choices)</i>	Working full-time	Working part-time or in temporary work	Unemployed and seeking work	Unemployed but not seeking work (e.g., student, retired, disabled, unpaid primary caregiver)	
What is your current work situation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. <b>Question Origin:</b> <i>PRAPARE tool (slightly modified question/answer choices)</i>				Yes	No
Do you have health insurance?				<input type="checkbox"/>	<input type="checkbox"/>

### 1.5.1 Recommended action – Question 1:

- Determine if current working situation is a barrier to their health or well-being.
- If individual is able to work and seeking assistance, refer to appropriate resources, e.g., employment security, Health Profession Opportunity Project (HPOP), community college systems, ESL classes, Vocational Rehab, Employment Security.
- Refer to [Employment and Entitlement Pathways](#).

### 1.5.2 Recommended action for negative response – Question 2:

- Refer to care coordinator who can help application submission and advise for next steps for acceptance or denial of insurance
- If no care coordination, refer to Local DHHS Office to start application process and to determine eligibility
- Refer to [Employment and Entitlement Pathways](#).

## 1.6 HOUSING

Having housing is an essential component to one’s well-being. The impacts of unmet social needs such as housing can be significant and growing evidence indicates addressing these social needs may help reverse their damaging health effects. Lack of housing may include:

- homelessness or couch surfing
- poor housing quality
- inability to pay a mortgage or rent

1. <b>Question Origin:</b> PRAPARE tool (slightly modified question – added homelessness inquiry)	Yes	No
Are you worried about losing your housing or are you homeless?	<input type="checkbox"/>	<input type="checkbox"/>

### 1.6.1 Recommended action for positive response – Question 1:

- Determine if situation is urgent. If so, contact appropriate community housing resources including emergency shelters
- Assess cause of inadequate housing; assess/identify support systems that may be able to help with housing issues
- If needed, refer to housing pathways such as to the local housing agency to complete a housing application form
- Follow up in 48 hours to check if patient is still in need of immediate housing
- Refer to [Housing Pathways](#).

## 1.7 FUNCTIONAL STATUS and (INSTRUMENTAL) ACTIVITIES OF DAILY LIVING (ADL/IADL)

These questions provide information on the patient's physical, psychological, social and role functions. It can be used both to screen initially for problems and to monitor the patient over time. Basic needs such as heat, food, transportation are discussed. ADL and IADL questions help to determine if the patient is able to live independently or to identify needed assistance they may not currently have.

1. <b>Question Origin:</b> PRAPARE tool (slightly modified question to ask specifically about utilities)	Yes	No
Are you currently having issues at home with your utilities such as your heat, electric, natural gas or water?	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Question Origin:</b> PRAPARE tool (slightly modified question to ask specifically about food)	Yes	No
Do you/your family worry about whether your food will run out and you won’t be able to get more?	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Question Origin:</b> PRAPARE tool (slightly modified question to be Y/N and added school)	Yes	No
Has lack of transportation kept you from medical appointments, meetings, work, school or from getting things needed for daily living?	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Question Origin:</b> DSM-5 Level 1 tool (slightly modified question)– impact on ADLs/IADLs	Yes	No
Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?	<input type="checkbox"/>	<input type="checkbox"/>

**5. Question Origin: Subset list of ADLs/IADLs**

Do you need assistance with any of the following tasks (**check all that apply**)?

- Bathing/Showering       Toileting       Dressing       Maintaining Personal Hygiene  
 Taking Your Medications       Preparing Meals       Feeding Yourself      Other: \_\_\_\_\_

**1.7.1 Recommended action for positive response – Question 1:**

- a. Determine if situation is urgent. If so, contact appropriate community resources including emergency shelters
- b. Provide information/brochure on utilities assistance programs available at city/county level; help client prepare for meetings with required documentation
- c. Connect with available community resources e.g. Salvation Army rental and fuel assistance services
- d. Follow up with patient/client within 7 days
- e. Refer to [Functional Status Pathways](#).

**1.7.2 Recommended action for positive response – Question 2:**

- a. Determine if situation is urgent. If so, contact appropriate community resources including local food pantries or soup kitchens
- b. Educate patient on resources in the community; determine eligibility and apply for food stamps or meals on wheel or SNAP
- c. Connect family with available community resources e.g. Salvation Army rental and fuel assistance services
- d. Follow up with patient/client within 48 hours
- e. Refer to [Functional Status Pathways](#).

**1.7.3 Recommended action for positive response – Question 3:**

- a. Assess support systems that may be able to help with transportation such as family/friends;
- b. Educate regrading local transportation options such as public transportation system or eligibility for transportation subsidy
- c. Refer to appropriate organization as indicated, e.g., NH Medicaid Coordinated Transportation Solutions (CTS); MCO approved transportation
- d. Determine if client qualifies for services based on disability or insurer includes rides and gas reimbursement through Medicaid
- e. Refer to [Functional Status Pathways](#).

**1.7.4 Recommended action for positive response – Question 4:**

- a. Refer patient to PCP for age/developmental assessment, identifying PCP and scheduling appointment while patient in office, ensure closed-loop referral.
- b. PCP provider completes age/developmental assessment; makes referral to appropriate provider as indicated
- c. Refer to [Functional Status Pathways](#).

- 1.7.5 Recommended action for positive response – Question 5:
- If appropriate, refer patient to PCP for age/developmental ADL/iADL & cognitive assessment, identifying PCP and scheduling appointment while patient in office, ensure closed-loop referral.
  - PCP provider completes age/developmental ADL/iAD & cognitive assessment; makes referral to appropriate provider as indicated
  - Determine if client qualifies for services based on disability or insurer includes services reimbursement through Medicaid
  - Refer to [Functional Status Pathways](#).

## 1.8 FAMILY & SUPPORT SERVICES

This question can help to determine the patient’s support system within the community and family structure based on their physical and emotional needs:

- is the patient at risk for being isolated?
- are they properly connected to support their SDOH needs?
- do they need help in getting connected to community support systems?

<b>1. Question Origin: PRAPARE tool</b>	Less than once a week	1 – 2 times a week	3 – 5 times a week	5 or more times a week
How often do you see or talk to people that you care about and feel close to? (e.g., talking to friends on the phone, visiting friends or family, going to a faith-based service/group or club meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1.8.1 Recommended action for positive response (Less than once a week) – Question 1:
- Explore and assess if issue due to physical or behavioral health issue (including SUD) and create care plan and refer to appropriate health care professional
  - Identify and refer to community services such as support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client choice
  - Refer to [Family & Support Services](#).

## 1.9 LEGAL

Legal issues can have impacts on many fronts including healthcare services. These questions are to identify those areas and determine if the patient requires assistance to getting them resolved and to consider who might be the right person to discuss what impact they may have in their general well-being. These may include disability or social security, criminal justice, guardianship etc.

<b>1. Question Origin: Social Determinants of Health (SDOH)</b>	Yes	No
Do you have any legal issues that are getting in the way of your health or healthcare or your general well-being?	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin: Social Determinants of Health (SDOH)</b>		
If yes to legal issues, what areas are most impacted ( <b>check all that apply</b> )?		
<input type="checkbox"/> Housing <input type="checkbox"/> Financial <input type="checkbox"/> Employment <input type="checkbox"/> Transportation <input type="checkbox"/> Family <input type="checkbox"/> Healthcare		
Other: _____		

### 1.9.1 Recommended action for positive response – Question 1 & 2:

- Use interview to explore; assess/identify areas of impact based on question 2; refer to appropriate resources/organizations as indicated in the legal pathways
- Assist patient/client prepare for meeting with required documentation on the case.
- Follow up with client to check if client made the appointment and discuss an intervention action plan
- Refer to [Legal Pathways](#).

## 1.10 DEPRESSION SCREENING – PHQ-2

The purpose of this screening is to identify those at risk of developing or having depression. Depression can be subtle or crippling, affecting both physical and mental health.

As per UPSTF, “depression is among the leading causes of disability in persons 15 years and older. It affects individuals, families, businesses, and society and is common in patients seeking care in the primary care setting. Depression is also common in postpartum and pregnant women and affects not only the woman but her child as well.” The USPSTF found convincing evidence that screening improves the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women.

<b>1. Question Origin: PHQ-2</b>				
Over the <i>last 2 weeks</i> , 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 1.10.1 Recommended action for positive response (greater than a score of 3) – Question 1 (PHQ-2):
- Patients who screen positive on PHQ-2, 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
  - Follow up with client - check if client made the recommended referral appointment if applicable
  - Provide education materials on depression concerns and wellness
  - Refer to community support services if applicable such as peer support, community organizations, and faith based supports
  - Refer to [Depression Pathways](#).

### 1.11 SUBSTANCE USE (including Tobacco Use)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The following questions are to determine if the patient is currently or at risk of having a substance use disorder including tobacco use.

<b>1. Question Origin:</b> DSM-5 Level 1 tool (slightly modified question)					Yes	No
Do you currently or have you ever smoked cigarettes or used any other smokeless tobacco products? (E.g. chewing tobacco, snuffs, dissolvable, vapor cigarettes, etc.)					<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin:</b> DSM-5 Level 1 tool (slightly modified question) - SBIRT	Never	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How many times in the past year have you used an illegal drug or used a prescription medication not as prescribed?	<input type="checkbox"/>					
<b>3. Question Origin:</b> : AUDIT tool (slightly modified answer choices)	Never	Less than monthly	Monthly	Weekly	Daily/ almost daily	
How often do you have a drink containing alcohol?	<input type="checkbox"/>					
<b>4. Question Origin:</b> AUDIT-C tool	Never	Less than monthly	Monthly	Weekly	Daily/ almost daily	
How often have you had 5 or more drinks containing alcohol in a day?	<input type="checkbox"/>					

- 1.11.1 Recommended action for positive response – Question 1:
- Any current tobacco use places an individual at risk. Advise/educate all tobacco users on risks and harm of tobacco use.
  - Assess the readiness to quit
  - Provide supportive counseling for individuals seeking help to quit smoking

- d. Develop treatment plan with patient-identified goals, including community support groups on tobacco cessation
- e. Connect patient with tobacco cessation program and support groups if patient is willing.
- f. Refer to [Substance Use \(Tobacco Use\) Pathways](#).

**1.11.2 Recommended action for positive response (1 or 2 or greater) – Question 2:**

- a. Brief counseling/information and education on risks and harm
- b. Follow-up with full DAST-10 screening/assessment, if not used initially
- c. Provide “warm hand-off” to behavioral health specialist/clinician for further assessment
- d. Refer to a “higher level of care” if appropriate and engage in continuing long-term outpatient care with monitoring and adjustments to treatment
- e. Offer pharmacotherapy
- f. Referral to BH or Social Worker or Community Services
- g. Refer to [Substance Use \(Illegal Drug Use\) Pathways](#).

**1.11.3 Recommended action for positive response (greater than 3) - Question 3:**

- a. Brief counseling/information and education on risks and harm
- b. Conducting AUDIT-10 assessment recommended
- c. Refer to [Substance Use \(Alcohol\) Pathways](#).

**1.11.4 Recommended action for positive response (greater than 2) - Question 4:**

- a. Supportive counseling and education on risks and harm
- b. Conducting AUDIT-10 assessment recommended
- c. Refer to [Substance Use \(Alcohol\) Pathways](#).

## **1.12 RISK ASSESSMENT (including Suicide Risk and Intimate Partner Violence)**

According to USPSTF: In 2010, suicide accounted for more than 1.4 million years of potential life lost before age 85 years, or 4.3% of total years of potential life lost in the United States based on Centers for Disease Control and Prevention Years of Potential Life Lost (YPLL) Reports, 1999–2010. As per *Am J Psychiatry*. 2002;159(6):909-16, past studies estimated that 38% of adults (50% to 70% of older adults) visited their primary care provider within 1 month of dying by suicide. As per *Academic Pediatrics*. 2011;11(5):422-6, nearly 90% of suicidal youths were seen in primary care during the previous 12 months<sup>5</sup>

Effective interventions generally included ongoing support services which included multiple visits that focused on counseling , addressed multiple risk factors (not just IPV), included parenting support for new mothers, and provided a range of emotional support and behavioral and social services . Studies that only included brief interventions and provided information about referral options were generally ineffective

<b>1. Question Origin: PRAPARE tool</b>		Yes	No	
In the past year, have you been afraid of your partner or ex-partner?		<input type="checkbox"/>	<input type="checkbox"/>	
<b>2. Question Origin: PRAPARE tool</b>		Yes	No	
Do you feel physically and emotionally safe where you currently live?		<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. Question Origin: PHQ-9</b>				
Over the <i>last 2 weeks</i> , how often have you been bothered by:	Not at all (0)	Several Day (1)	More than half the days (2)	Nearly every day (3)
Thoughts that you would be better off dead, or of hurting yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1.12.1 Recommended action for positive response – Question 1 & Question 2:

- a. Must be in compliance with reporting policies, rules, and laws.
- b. Use interview to explore, assess with more thorough screening tools - US Preventative Services Task Force (USPSTF) suggested effective assessment tools include: Hurt, Insult, Threaten, Scream (HITS) (English and Spanish versions); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST).
- c. Provide Domestic Violence Safety Plan (DVSP) and education on risks and harm
- d. Identify support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client choice and as per reporting guidelines
- e. Referral to BH or Social Worker or Community Services
- f. Follow up can include mentoring, home visits, re-assessment of current risk
- g. Refer to [Risk Assessment \(Intimate Partner Violence\) Pathways](#).

1.12.2 Recommended action for positive response (anything greater than 0) – Question 3:

- a. Must be in compliance with reporting policies, rules, and laws
- b. USPSTF recommends referring to pharmacotherapy, case management and/or psychotherapy such as cognitive behavioral therapy and related approaches, including dialectical behavior therapy, problem-solving therapy, and developmental group therapy.
- c. The USPSTF recommends that primary care clinicians screen adolescents and adults for depression when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up.
- d. Primary care clinicians should also focus on patients during periods of high suicide risk, such as immediately after discharge from a psychiatric hospital or after an emergency department visit for deliberate self-harm. Recent evidence suggests that interventions during these high-risk periods are effective in reducing suicide deaths
- e. Refer to Risk [Assessment \(Suicide Risk\) Pathways](#).

### 1.12.3 CHILDREN ONLY: Development and behavioral screening

Lastly, there is a pediatric domain to screen pediatric development using age appropriate standardized and validated tools. These will be addressed separately.

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## 2. Referral Pathways Table

Domain	Question	Potential Pathways
2.1 Medical	<a href="#">Do you see your doctor at least once a year for a physical or well care visit?</a>	<ul style="list-style-type: none"> <li>• City of Nashua Public Health</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• Harbor Homes</li> <li>• Lamprey Health Care</li> <li>• St. Joseph Hospital &amp; Physician Practices</li> <li>• MCO Provider Search Directory</li> <li>• City of Nashua Public Health</li> </ul>
	<a href="#">Have you had an emergency room (ED) visit in the last 90 days?</a>	<ul style="list-style-type: none"> <li>• City of Nashua Public Health</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• Harbor Homes</li> <li>• Lamprey Health Care</li> <li>• St. Joseph Hospital &amp; Physician Practices</li> <li>• Home Health and Hospice</li> <li>• GNMHC - Community Council</li> <li>• MCO Provider Search Directory</li> </ul>
2.2 Education and Health Literacy	<a href="#">Are you currently attending school?</a>	<ul style="list-style-type: none"> <li>• School System</li> <li>• The Youth Council</li> </ul>
	<a href="#">What is the highest level of school you have finished?</a>	<ul style="list-style-type: none"> <li>• School System</li> <li>• Adult Learning Center (potential IDN member)</li> <li>• Nashua Public Library</li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• Southern NH Services</li> <li>• Granite State Independent Living</li> <li>• Teach Back: <a href="http://www.teachbacktraining.org">http://www.teachbacktraining.org</a></li> <li>• SNH Services</li> </ul>

2.3 Employment and Entitlement	<a href="#">What is your current work situation?</a>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• Granite State Independent Living (GSIL)</li> <li>• ESL (English as a Second Language) classes</li> <li>• NH Employment Security</li> <li>• Health Profession Opportunity Project (HPOP)</li> <li>• SNH Services</li> <li>• <a href="https://www.auntbertha.com/">https://www.auntbertha.com/</a></li> <li>• NH 211</li> </ul>
	<a href="#">Do you have health insurance?</a>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• Department of Health, Human Services (DHHS)</li> <li>• NH Insurance Department: <a href="https://www.nh.gov/insurance/consumers/mp_plans.htm">https://www.nh.gov/insurance/consumers/mp_plans.htm</a></li> <li>• NH 211</li> </ul>
2.4 Housing	<a href="#">Are you worried about losing your housing or are you homeless?</a>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• Front Door Agency</li> <li>• Harbor Homes</li> <li>• Southern NH Services</li> <li>• The Front Door Agency</li> <li>• Nashua Welfare Department</li> <li>• NH Housing Authority</li> <li>• NH 211</li> </ul>
2.5 Functional Status and ADL/IADL	<a href="#">Are you currently having issues at home with your utilities such as your heat, electric, natural gas or water?</a>	<ul style="list-style-type: none"> <li>• SNH Services – Fuel Assistance</li> <li>• Nashua Welfare Department</li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> </ul>
	<a href="#">Do you/your family worry about whether your food will run out and you won't be able to get more?</a>	<ul style="list-style-type: none"> <li>• St. Joseph Community Services</li> <li>• Nashua Soup Kitchen</li> <li>• Department of Health, Human Services (DHHS)</li> <li>• WIC Program</li> <li>• Nashua Welfare Department</li> <li>• Aunt Bertha: <a href="https://www.auntbertha.com/">https://www.auntbertha.com/</a></li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> </ul>
	<a href="#">Has lack of transportation kept you from medical appointments, meetings, work,</a>	<ul style="list-style-type: none"> <li>• Nashua Welfare Department</li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> </ul>

	<p><a href="#"><u>school or from getting things needed for daily living?</u></a></p>	<ul style="list-style-type: none"> <li>• NH Medicaid Coordinated Transportation Solutions (CTS): <a href="http://www.ctstransit.com">www.ctstransit.com</a>;</li> <li>• MCO Approved Transportation</li> <li>• Aunt Bertha: <a href="https://www.auntbertha.com/">https://www.auntbertha.com/</a></li> <li>• Local Public Transportation</li> </ul>
	<p><a href="#"><u>Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?</u></a></p>	<ul style="list-style-type: none"> <li>• City of Nashua Public Health</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• Harbor Homes</li> <li>• Healthy at Home</li> <li>• Lamprey Health Care</li> <li>• St. Joseph Primary Care Practice Network</li> <li>• MCO Provider Search Directory</li> </ul>
	<p><a href="#"><u>Do you need assistance with any of the following tasks - ADLs?</u></a></p>	<ul style="list-style-type: none"> <li>• Life Coping</li> <li>• Home Health and Hospice</li> <li>• Gateways Community Services</li> <li>• Granite State Independent Living (GSIL)</li> <li>• Healthy at Home</li> <li>• Hillsborough County Nursing Home &amp; Corrections</li> <li>• MCO Home Health Care Services</li> </ul>

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<p>2.6 Family and Support Services</p>	<p><u>How often do you see or talk to people that you care about and feel close to? (e.g., talking to friends on the phone, visiting friends or family, going to a faith-based service/group or club meeting)</u></p>	<ul style="list-style-type: none"> <li>• GNMHC - Community Council</li> <li>• Local Family Support Groups</li> <li>• Revive Recovery Center</li> <li>• H.E.A.R.T.S</li> <li>• Ascentria Care Alliance</li> <li>• Granite State Independent Living (GSIL)</li> <li>• The Emmaus Institute</li> <li>• NAMI NH</li> <li>• Life Coping</li> <li>• LaMora Psychological Associates</li> <li>• Hillsborough County Nursing Home &amp; Corrections</li> <li>• Al Anon, AA, NA, etc.</li> </ul>
<p>2.7 Legal</p>	<p><u>Do you have any legal issues that are getting in the way of your health or healthcare or your general well-being?</u> <u>If yes to legal issues, what areas are most impacted (check all that apply)?</u></p>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• NH Legal Aid</li> <li>• Nashua Pubic Defender’s Office &amp; other Legal Services: <a href="https://www.nashuanh.gov/820/Legal-Contacts">https://www.nashuanh.gov/820/Legal-Contacts</a></li> </ul>
<p>2.8 Depression</p>	<p><u>Little interest or pleasure in doing things?</u> <u>Feeling down, depressed, or hopeless?</u></p>	<ul style="list-style-type: none"> <li>• Lamprey Health Care InteGreat</li> <li>• LaMora Psychological Associates</li> <li>• GNMHC - Community Council (Links under “Services” &amp; “Resources”)</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• SNHMC BH</li> <li>• Harbor Homes</li> <li>• NAMI NH</li> <li>• New Hampshire Hospital</li> </ul>
<p>2.9 Substance Use (Tobacco Use)</p>	<p><u>Do you currently or have you ever smoked cigarettes or used any other smokeless tobacco products? (E.g. chewing tobacco, snuffs, dissolvable, vapor cigarettes, etc.)</u></p>	<ul style="list-style-type: none"> <li>• Dartmouth Hitchcock</li> <li>• YMCA – Tobacco cessation programs</li> <li>• QuitNow NH 1-800-QUIT-NOW</li> <li>• US DHHS Agency for Healthcare Research &amp; Quality: <a href="https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/index.html">https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/index.html</a></li> </ul>

<p>2.10 Substance Use (Illegal Drug Use)</p>	<p><u><a href="#">How many times in the past year have you used an illegal drug or used a prescription medication not as prescribed?</a></u></p>	<ul style="list-style-type: none"> <li>• GNMHC - Community Council</li> <li>• Harbor Homes</li> <li>• Keystone Hall</li> <li>• H.E.A.R.T.S.</li> <li>• Revive Recovery Center</li> <li>• The Youth Council</li> <li>• The Emmaus Institute</li> <li>• Oasis Recovery</li> <li>• SNHMC</li> <li>• SNHMC ED/Access Team</li> <li>• St. Joe's ED</li> <li>• Dartmouth Hitchcock</li> <li>• Merrimack River Medical Services</li> <li>• Nashua Dept. of Public Health</li> <li>• Community Connections Guide to Recovery:</li> <li>• <a href="https://www.nashuanh.gov/DocumentCenter/View/11231/Guide-to-Recovery-PDF">https://www.nashuanh.gov/DocumentCenter/View/11231/Guide-to-Recovery-PDF</a></li> </ul>
<p>2.11 Substance Use (Alcohol)</p>	<p><u><a href="#">How often do you have a drink containing alcohol?</a></u> <u><a href="#">How often have you had 5 or more drinks containing alcohol in a day?</a></u></p>	<ul style="list-style-type: none"> <li>• GNMHC - Community Council</li> <li>• Harbor Homes</li> <li>• Keystone Hall</li> <li>• Dartmouth Hitchcock</li> <li>• H.E.A.R.T.S.</li> <li>• Revive Recovery Center</li> <li>• The Youth Council</li> <li>• The Emmaus Institute</li> <li>• Oasis Recovery</li> <li>• Merrimack River Medical Services</li> <li>• SNHMC</li> <li>• SNHMC ED/Access Team</li> <li>• St. Joe's ED</li> </ul>
<p>2.12 Risk Assessment (Intimate Partner Violence)</p>	<p><u><a href="#">In the past year, have you been afraid of your partner or ex-partner?</a></u> <u><a href="#">Do you feel physically and emotionally safe where you currently live?</a></u></p>	<ul style="list-style-type: none"> <li>• Bridges Domestic and Sexual Violence Support</li> </ul>
<p>2.13 Risk Assessment (Suicide Risk)</p>	<p><u><a href="#">Thoughts that you would be better off dead, or of hurting yourself?</a></u></p>	<ul style="list-style-type: none"> <li>• GNMHC - Community Council</li> <li>• Harbor Homes</li> <li>• NAMI NH</li> <li>• SNHMC</li> <li>• SNHMC ED/Access Team</li> <li>• St. Joseph Hospital ED</li> </ul>

## Appendix - Glossary

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**American Academy of Family Physicians (AAFP)** – The American Academy of Family Physicians was founded in 1947 to promote the science and art of family medicine. It is one of the largest medical organizations in the United States, with over 131,400 members. The AAFP was instrumental in establishing family medicine as a recognized medical specialty; a certifying board was approved by the [American Board of Medical Specialties](#) in 1969. The AAFP is headquartered in [Leawood, Kansas](#).

**Assessment Measures (Assess\_Screen.x)** – Clinical outcome measures are used by the NH DSRIP (Delivery System Reform Incentive Payment) program to evaluate Integrated Delivery Network (IDN) performance for incentive payment. These measures are part of CMS approved protocols (and hence the IDN contracts) and also allow the Department (NH Department of Health and Human Services) to support DSRIP oversight and evaluate overall program impact.

**Attributed Population** – Every NH Medicaid beneficiary is attributable to one (and only one) IDN for the basis of the DSRIP demonstration funding formula and for the measurement of performance metrics for each IDN. The principle of the attribution methodology is that beneficiaries should be attributed to IDNs based upon where they currently receive their care, however, that is not always possible to identify, so attribution is based upon four factors: 1) use of long-term care facility providers, 2) use of mental health/substance use disorder providers (including Community Mental Health Center) providers, 3) use of primary care providers, 4) geographic criteria (when necessary).

**Behavioral Health Population** – DHHS determined subset of the Medicaid population that is broadly likely using, at risk for, or in need of behavioral health care.

**Behavioral Health** – Behavioral health includes mental health services as well as Substance Use Disorder (SUD) services.

**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. The assessment is intended to be a standardized screening process that integrates medical, behavioral and social needs and results in the identification of needs with appropriate referrals and linkages. Standardization results from the screening of a core set of domain areas. The IDN is required to develop and implement CCSA protocols that detail the requirements for the assessment process, documentation, expectations of providers and training plan, tools used, and referral process for assessment findings and individual needs.

**CIHS** - SAMHSA-HRSA Center for Integrated Health Solutions which is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care

**CIHS’ Standard Six-Level Framework for Levels of Integrated Healthcare Model** - promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions

**DHHS** – Department of Health and Human Services.

**Direct Secure Messaging (DSM)** – The ability to transmit protected health information (PHI) between providers which includes secure sharing of documents related to information sharing and care coordination.

**DSRIP** - Delivery System Reform Incentive Payment is a vehicle for states to improve health outcomes and population health by reforming the health care delivery system to be more effective in addressing both physical and behavior health for the Medicaid population.

**Electronic health record (EHR) or other electronic tracking system** – For the purposes of this document, an Electronic Health Record or other electronic tracking system, includes a treatment provider's medical record system (e.g., Epic, GE Centricity), a platform that allows IDN member entities to store or query data, or the IDN's reporting service, MAeHC.

**Event Notification Service (ENS)** – Allows providers to receive notifications through an automated service that provides timely alert messages when patients are discharged from a hospital or emergency department.

**Integrated Delivery Network (IDN)** - The provider networks that form regional coalitions and collectively pool funds as a single region, based upon attributed population.

**Institute for Healthcare Improvement and National Patient Safety Foundation (IHI and NPSF)** – These two organizations both out of the Boston, MA area, joined forces to become one organization as of May 1, 2017. NPSF is known for its thought leadership and research on patient safety, while IHI is a considered a leader in redesigning healthcare to be safer and more efficient. This document references a specific study by this organization, "Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era", published in 2017.

**IDN's Medicaid Billing Provider** – A provider who accepts NH Medicaid as part of the IDN.

**Medicaid Population** – For the purpose of DSRIP demonstration, the Medicaid population includes those NH residents enrolled in a Medicaid Managed Organization (NH Healthy Families or WellSense), a Qualified Health Plan as part of NH's premium assistance program (Ambetter commercial plan with PAP indicator, Anthem commercial plan with PAP in group name, Harvard Pilgrim commercial plan with PAP in group name, or Minuteman commercial plan with PAP in group name, which is plan sunsetting 12/31/17) or a Medicaid Fee for Service (FFS) plan, regardless of whether the person also has coverage from another source (e.g., Medicare, commercial insurance).

**Myers and Stauffer, LC (MSLC)** – Myers and Stauffer provides professional accounting, consulting, data management and analysis services to state and federal agencies managing government-sponsored health care programs. They have been contracted by NH DHHS to facilitate the sharing of best practices and lessons learned to support Integrated Delivery Network (IDN) project implementation and attainment of the state's overall waiver goals.

**Shared Care Plan (SCP)** – An electronic tool for information sharing between providers for case management and treatment plan implementation across a Multi-Disciplinary Core Team.

**Special Terms and Conditions (STC's)** - Special Terms and Conditions enable the State of NH (and the IDNs) to operate the demonstration, setting forth the nature, character, and extent of federal involvement in the demonstration and are approved through December 31, 2020

**USPSTF** – U.S. Preventive Services Task Force is an independent panel (appointed by a federal agency) of national experts in disease prevention and evidence-based medicine that works to improve the health of the population by making evidence-based recommendations about clinical preventive service.

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# IDN-3 Youth CCSA Overview and Pathways

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GUIDELINES AND RECOMMENDATIONS

V1.1

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Delivery System Reform Incentive Payment (DSRIP)  
Integrated Delivery Network (IDN) 3

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## Change Log

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<b>Date</b>	<b>Change</b>	<b>Version</b>
11/15/18	Document Created	V1.0
11/29/18	Document Updated for some recommendations/pathways based on feedback	V1.1

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# Introduction

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New Hampshire's *Building Capacity for Transformation* Section 1115 demonstration aims to transform the way care is delivered to some of the most medically complex and costly Medicaid beneficiaries in the state as well as to children, youth and adults with undiagnosed or untreated behavioral health conditions. This will be accomplished through transforming the behavioral health delivery system through:

- Integrating physical and behavioral health to better address the full range of beneficiaries' needs and input to development of patient shared care plans; the goal is to have a shared collaborative approach between primary care and mental health care where the sense is that these are OUR patients.
- Expanding provider capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

## 2. The Comprehensive Core Standard Assessment (CCSA)

Use of a Comprehensive Core Standard Assessment process (conducted at a minimum annually) is the basis for an individualized care plan used by the care team to guide the treatment and management of the target sub-population (IDN attributed Medicaid beneficiaries). The CCSA is intended to be a standardized screening process that integrates medical, behavioral and social needs and results in the identification of needs with appropriate referrals and linkages. Standardization results from the screening of a core set of domain areas. These domains include the following:

1. Demographic
2. Medical
3. Education
4. Employment and Entitlement
5. Housing
6. Functional status (activities of daily living, instrumental activities of daily living, cognitive functioning including transportation)
7. Family and Support Services
8. Legal
9. Depression screening
10. Substance Use (including Tobacco Use)
11. Risk assessment (including Suicide Risk and Intimate Partner Violence)
12. Pediatric developmental screening

The IDN-3 Clinical Governance Committee approved the IDN Comprehensive Core Standardized Assessment (CCSA) tool to address each domain defined in the DHHS Special Terms and Conditions (STCs). Below is the crosswalk of IDN 3 CCSA tool to each domain, recommendations for positive outcomes and potential associated pathways.

## 2.1 DEMOGRAPHICS

It was decided at Clinical Committee meeting that other demographics such as age, gender, race, ethnicity, are already being captured as part of provider intake forms or within EHR systems as an existing patient, thus would be duplication if also captured as part of the CCSA tool.

First Name, Middle Name, Last Name of Patient		Patient Date of Birth (dd/mm/yyyy):  ____/____/____
First Name, Middle Name, Last Name of Person Filling Out This Form:		Relationship to Patient
How confident are you filling out forms for your child?  <input type="checkbox"/> Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely		
Are You the Legal Parent or Guardian?  <input type="checkbox"/> Yes <input type="checkbox"/> No	Today's Date  ____/____/____	Initials of Reviewer (Please leave blank)

## 2.2 Recommended action:

- a. Capturing patient name and date of birth (DOB).
- b. Since this is for youth/child and someone else may be filling out the CCSA, also capture their information:
  - their name
  - their relationship to the patient
  - their comfort level filling out the form for the child
  - are they the legal guardian of the child
- c. Determine if patient needs assistance with language or with filling out the form - use provider current policy & procedure

## 2.3 MEDICAL

To reinforce the benefits of routine physical health assessments, care for the patient and to determine if emergency department visits can be reduced by providing better continuum of care. Some patients may not know that annual physicals and well care visits are at no cost to the patient and can:

- help patients understand their current health status and identify actions to improve their health
- improve relationships with their provider by creating an environment for stimulating open dialog and identify areas which are of concern to the patient
- help address and monitor chronic conditions more effectively to reduce or avoid emergency care
- help identify issues requiring referrals to other providers or community services
- have many other positive outcomes

<b>1. Question Origin:</b> PRAPARE tool (slightly modified question)	Yes	No
Does your child see his/her doctor at least once a year for a physical or well care visit?	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin:</b> DHHS Feedback – intent is to start conversation on use of ED	Yes	No
Has your child had an emergency room (ED) visit in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Question Origin:</b> DHHS Feedback – intent is to start conversation on use of ED	Yes	No
Does your child exercise or play sports that make him/her sweat or breathe hard for 30 minutes at least 3 times per week?	<input type="checkbox"/>	<input type="checkbox"/>

- 2.3.1 Recommended action for negative response – Question 1:
- Inquire why. Are they using ED or immediate care instead?
  - Ask if they are aware that well care visits are covered 100% if patient has insurance
  - Facilitate connection with primary care provider for an annual wellness visit
  - Refer to [Medical Referral Pathways](#).
- 2.3.2 Recommended action for positive response – Question 2:
- Assess reason for ED visit
  - Review patient history for reason for repeated ED visit
  - Provide educational resources on community crisis prevention
  - Evaluate for eligibility to access available community resources and referral to more intensive BH treatment services.
  - Refer to [Medical Referral Pathways](#).
- 2.3.3 Recommended action for negative response – Question 3:
- Inquire why. What activities do they participate in?
  - Ask if they are aware that well care visits are covered 100% if patient has insurance
  - Facilitate connection with primary care provider for an annual wellness visit
  - Refer to [Medical Referral Pathways](#).

## 2.4 EDUCATION

This domain's focus is to identify and understand specific knowledge and skill set the patient has or will need to have to make care decisions, participate in their care, and continue care at home as well as how education barriers might impact their financial well-being. This provides an opportunity to partner with the patient to explore what types of barriers may be present which prevents the patient from receiving further education and/or establishing/reviewing educational goals and possible pathways. Some patient variables to consider during assessment are:

- their literacy, educational level, and language
- emotional barriers and motivations
- physical and cognitive limitations and
- understanding the patient's preferred way of learning

<b>1. Question Origin:</b> DHHS Feedback – intent is to start conversation about education, especially for those who are school age & not attending school	Home Schooled	Yes	No	Not Applicable
Is your child enrolled in school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.4.1 Recommended action for negative response – Question 1:

- a. If minor, inquire why they are not attending school at the expected grade level.
- b. Refer to [Education Pathways](#).

## 2.5 EMPLOYMENT AND ENTITLEMENT

This domain is to help the provider determine if the patient has financial barriers either for having access to their basic needs or for continued growth and potential restrictions to access to the needed health care. This can be an opportunity to partner with client to provide assistance in:

- resume development, cover letter writing and/or filling out application(s)
- preparing for appointments or job interviews (e.g. childcare, transportation, clothing needs)
- contacting or referring to employment resources
- getting health insurance

<b>1. Question Origin:</b> PRAPARE tool (slightly modified question/answer choices)	Yes	No	
Does your child have health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2. Question Origin:</b> PRAPARE tool (slightly modified answer choices)	Yes	No	Not Applicable
Does your child hold a job?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.5.1 Recommended action for negative response – Question 1:

- a. Refer to care coordinator who can help application submission and advise for next steps for acceptance or denial of insurance.
- b. If no care coordination, refer to Local DHHS Office to start application process and to determine eligibility.
- c. Refer to [Employment and Entitlement Pathways](#).

2.5.2 Recommended action – Question 2:

- a. Determine if current working situation is a barrier to their health or well-being
- b. If individual is able to work and seeking assistance, refer to appropriate resources, e.g., employment security, Health Profession Opportunity Project (HPOP), community college systems, ESL classes, Vocational Rehab, Employment Security or refer to Employment and Entitlement Pathways
- c. Refer to [Employment and Entitlement Pathways](#).

## 2.6 HOUSING

Having housing is an essential component to one’s well-being. The impacts of unmet social needs such as housing is well documented and growing evidence indicates addressing these social needs may help reverse their damaging health effects. Lack of housing may include:

- homelessness or couch surfing
- poor housing quality
- inability of the care giver to pay a mortgage or rent

1. <b>Question Origin:</b> PRAPARE tool (slightly modified question – added homelessness inquiry)	I have housing	I have housing today but am worried about losing housing in the future	I do not have housing
What is your housing situation for your child today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 2.6.1 Recommended action for positive response – Question 1:

- Determine if situation is urgent. If so, contact appropriate community housing resources including emergency shelters
- Assess cause of inadequate housing; assess/identify support systems that may be able to help with housing issues
- Follow up in 48 hours to check if patient is still in need of immediate housing
- Refer to [Housing Pathways](#).

## 2.7 FUNCTIONAL STATUS and (INSTRUMENTAL) ACTIVITIES OF DAILY LIVING (ADL/IADL)

These questions provide information on the patient's physical, psychological, social and role functions. It can be used both to screen initially for problems and to monitor the patient over time. Basic needs such as heat, food, transportation are discussed. ADL and IADL questions help to determine if the patient is able to live independently or to identify needed assistance they may not currently have.

1. <b>Question Origin:</b> PRAPARE tool (slightly modified question to ask specifically about utilities)	Yes	No
Are you currently having issues at home with your utilities (heat, electric, natural gas or water)?	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Question Origin:</b> PRAPARE tool (slightly modified question to ask specifically about food)	Yes	No
Do you/your family worry about whether your food will run out and you won’t be able to get more?	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Question Origin:</b> PRAPARE tool (slightly modified question to be Y/N and added school)	Yes	No
In the past 12 months, has lack of transportation kept you from keeping your child’s medical appointments, meetings, or from getting things needed for daily living?	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Question Origin:</b> PRAPARE tool	Yes	No

In the past 12 months, how hard is it for you to pay for your child's medical care and medications?	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Question Origin: Subset list of ADLs/IADLs</b>		
Does your child need assistance with any of the following tasks ( <b>check all that apply</b> )?		
<input type="checkbox"/> Bathing/Showering	<input type="checkbox"/> Toileting	<input type="checkbox"/> Dressing
<input type="checkbox"/> Taking Their Medications	<input type="checkbox"/> Grooming	<input type="checkbox"/> Feeding Themselves
		<input type="checkbox"/> Maintaining Personal Hygiene
		<input type="checkbox"/> Other: _____

- 2.7.1 Recommended action for positive response – Question 1:
- Determine if situation is urgent. If so, contact appropriate community resources including emergency shelters
  - Provide information/brochure on utilities assistance programs available at city/county level; help client prepare for meetings with required documentation
  - Connect with available community resources e.g. Salvation Army rental and fuel assistance services
  - Follow up with patient/client within 7 days
  - Refer to [Functional Status Pathways](#).
- 2.7.2 Recommended action for positive response – Question 2:
- Determine if situation is urgent. If so, contact appropriate community resources including local food pantries or soup kitchens
  - Educate patient on resources in the community; determine eligibility and apply for food stamps or meals on wheel or SNAP
  - Connect family with available community resources e.g. local food pantry
  - Follow up with patient/client within 48 hours
  - Refer to [Functional Status Pathways](#).
- 2.7.3 Recommended action for positive response – Question 3:
- Assess support systems that may be able to help with transportation such as family/friends
  - Educate regrading local transportation options such as public transportation system or eligibility for transportation subsidy
  - Refer to appropriate organization as indicated, e.g., NH Medicaid Coordinated Transportation Solutions (CTS); MCO approved transportation
  - Determine if client qualifies for services based on disability or insurer includes rides and gas reimbursement through Medicaid
  - Refer to [Functional Status Pathways](#).
- 2.7.4 Recommended action for positive response – Question 4:
- Refer to care coordinator who can help advise on possible options and for next steps
  - If no care coordination, refer to Local DHHS Office to start application process and to determine eligibility for further financial assistance
  - Refer to [Functional Status Pathways](#).

- 2.7.5 Recommended action for positive response – Question 5:
- If appropriate, refer patient to PCP for age/developmental ADL/iADL & cognitive assessment, identifying PCP and scheduling appointment while patient in office, ensure closed-loop referral.
  - PCP provider completes age/developmental ADL/iAD & cognitive assessment; makes referral to appropriate provider as indicated
  - Determine if client qualifies for services based on disability or insurer includes services reimbursement through Medicaid
  - Refer to [Functional Status Pathways](#).

## 2.8 FAMILY & SUPPORT SERVICES

This question can help to determine the patient’s support system within the community and family structure based on their physical and emotional needs:

- is the patient at risk for being isolated?
- are they properly connected to support their SDOH needs?
- do they need help in getting connected to community support systems?

<b>1. Question Origin:</b> PRAPARE tool	Less than once a week	1 – 2 times a week	3 – 5 times a week	5 or more times a week
How often does your child see or talk to people that they care about and feel close to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin:</b>		Hardly Ever	Some of the time	Often
How often does your child appear isolated from others?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 2.8.1 Recommended action for positive response (Less than once a week) – Question 1:
- Explore and assess if issue due to physical or behavioral health issue (including SUD) and create care plan and refer to appropriate health care professional
  - Identify and refer to community services such as support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client choice
  - Refer to [Family & Support Services](#).
- 2.8.2 Recommended action for positive response (Often) – Question 2:
- Explore and assess if issue due to physical or behavioral health issue (including SUD) and create care plan and refer to appropriate health care professional
  - Identify and refer to community services such as support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client choice
  - Refer to [Family & Support Services](#).

## 2.9 LEGAL

Legal issues can have impacts on many fronts including healthcare services. These questions are to identify those areas and determine if the patient requires assistance to getting them resolved and to consider who might be the right person to discuss what impact they may have in their general well-being. These may include disability or social security, criminal justice, guardianship etc.

<b>1. Question Origin: Social Determinants of Health (SDOH)</b>		
	Yes	No
Do you or your child have any legal issues that are getting in the way of your health or well-being of your child?	<input type="checkbox"/>	<input type="checkbox"/>

### 2.9.1 Recommended action for positive response – Question 1:

- a. Use interview to explore; assess/identify areas of impact of the legal issue; refer to appropriate resources/organizations as indicated in the legal pathways
- b. Assist patient/client prepare for meeting with required documentation on the case, if applicable.
- c. Follow up with client to check if client made progress and discuss an intervention action plan
- d. Refer to [Legal Pathways](#).

## 2.10 DEPRESSION SCREENING – PHQ-2

The purpose of this screening is to identify those at risk of developing or having depression. Depression can be subtle or crippling, affecting both physical and mental health.

As per UPSTF, “depression is among the leading causes of disability in persons 15 years and older. It affects individuals, families, businesses, and society and is common in patients seeking care in the primary care setting. Depression is also common in postpartum and pregnant women and affects not only the woman but her child as well.” The USPSTF found convincing evidence that screening improves the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women.

<b>1. Question Origin: PHQ-2</b>				
Does your child struggle with any of the following:	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- ### 2.10.1 Recommended action for positive response (greater than a score of 3) – Question 1 (PHQ-2):
- a. Patients who screen positive on PHQ-2, should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder
  - b. Develop a follow up intervention plan with patient/caregiver at the time of the screening.

- c. Refer anyone with moderate depression or higher for immediate behavioral health assessment
- d. Follow up with client/caregiver - check if client/caregiver made the recommended referral appointment if applicable
- e. Provide education materials on depression concerns and wellness
- f. Refer to community support services if applicable such as peer support, community organizations, and faith based supports
- g. Refer to [Depression Pathways](#).

## 2.11 SUBSTANCE USE (including Tobacco Use)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The following questions are to determine if the patient is currently or at risk of having a substance use disorder including tobacco use.

<b>1. Question Origin:</b> During the past 12 months, did your child:	Yes	No
Smoke any marijuana or hashish?	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin:</b> During the past 12 months, did your child:	Yes	No
Use anything else to get high? (includes illegal drugs, over the counter and prescription drugs, and anything that can be “sniffed” or “huffed”, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Question Origin:</b> During the past 12 months, did your child:	Yes	No
Drink any alcohol (more than a few sips)? (Do not count sips or alcohol taken during family or religious events)	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Question Origin:</b> During the past 12 months, did your child:	Yes	No
Use any tobacco products? (includes cigarettes, chewing tobacco, snuffs, dissolvable, vapor cigarettes, any smokeless tobacco products, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

### 2.11.1 Recommended action for positive response – Question 1 & 2:

- a. Brief counseling/information and education on risks and harm
- b. Follow-up with full DAST-10 screening/assessment, if not used initially
- c. Provide “warm hand-off” to behavioral health specialist/clinician for further assessment
- d. Refer to a “higher level of care” if appropriate and engage in continuing long-term outpatient care with monitoring and adjustments to treatment
- e. Referral to BH or Social Worker or Community Services
- f. Refer to [Substance Use \(Illegal Drug Use\) Pathways](#).

### 2.11.2 Recommended action for positive response - Question 3:

- a. Counseling/information and education on risks and harm
- b. Conducting AUDIT-10 assessment recommended
- c. Refer to [Substance Use \(Alcohol\) Pathways](#).

- 2.11.3 Recommended action for positive response – Question 4:
- Any current tobacco use places an individual at risk especially a child. Advise/educate on risks and harm of tobacco use.
  - Assess the readiness to quit
  - Provide supportive counseling for individuals seeking help to quit smoking
  - Develop treatment plan with patient-identified goals, including community support groups on tobacco cessation
  - Connect patient/caregiver with tobacco cessation program and support groups if patient is willing.
  - Refer to [Substance Use \(Tobacco Use\) Pathways](#).

## 2.12 RISK ASSESSMENT (including Suicide Risk)

According to USPSTF: In 2010, suicide accounted for more than 1.4 million years of potential life lost before age 85 years, or 4.3% of total years of potential life lost in the United States based on Centers for Disease Control and Prevention Years of Potential Life Lost (YPLL) Reports, 1999–2010. As per *Academic Pediatrics*. 2011;11(5):422-6, nearly 90% of suicidal youths were seen in primary care during the previous 12 months-

Effective interventions generally included ongoing support services which included multiple visits that focused on counseling , addressed multiple risk factors (not just IPV), included parenting support for mothers, and provided a range of emotional support and behavioral and social services . Studies that only included brief interventions and provided information about referral options were generally ineffective.

<b>1. Question Origin: PRAPARE tool</b>					Yes	No
Does your child feel physically and emotionally safe where you currently live?					<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Question Origin: PHQ-9</b>						
	Not at all (0)	Several Day (1)	More than half the days (2)	Nearly every day (3)		
Thoughts of suicide, feelings that he/she would be better off dead, or have thoughts of harming him/herself in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

- 2.12.1 Recommended action for positive response – Question 1:
- Must be in compliance with reporting policies, rules, and laws.
  - Use interview to explore, assess with more thorough screening tools - US Preventative Services Task Force (USPSTF) suggested effective assessment tools include: Hurt, Insult, Threaten, Scream (HITS) (English and Spanish versions); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF).

- c. Provide Domestic Violence Safety Plan (DVSP) and education on risks and harm
- d. Identify support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client choice and as per reporting guidelines
- e. Referral to BH or Social Worker or Community Services
- f. Follow up can include mentoring, home visits, re-assessment of current risk
- g. Refer to [Risk Assessment \(Physical Safety\) Pathways](#).

2.12.2 Recommended action for positive response (anything greater than 0) – Question 3:

- a. Must be in compliance with reporting policies, rules, and laws
- b. Use interview techniques to assess any significant events occurring in the child’s life which may adversely affect their mental wellbeing negatively
- c. The USPSTF recommends that primary care clinicians screen children for depression when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up.
- d. Primary care clinicians should also focus on patients during periods of high suicide risk, after an emergency department visit for deliberate self-harm. Recent evidence suggests that interventions during these high-risk periods are effective in reducing suicide deaths
- e. Identify support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client/caregiver choice and as per reporting guideline
- f. Refer to Risk [Assessment \(Suicide Risk\) Pathways](#).

2.13 Development and behavioral screening

<b>1. Questions Origin:</b>
Do you have any concerns related to your child’s development in the following areas: <b>(check all that apply)</b> ?
<input type="checkbox"/> Gross Motor Skills ( <i>larger movements your child makes with his arms, legs, feet, or his entire body</i> )
<input type="checkbox"/> Fine Motor Skills ( <i>smaller actions your child performs using fingers and toes or facial expressions</i> )
<input type="checkbox"/> Communication and speech
<input type="checkbox"/> Social Behavior

2.13.1 Recommended action for any positive response – Question 3:

- a. As per DHHS, pediatric providers will need to ensure that all children receive standardized, validated developmental screening, such as the ASQ:3 and/or ASQ SE at 9, 18, and 24/30 month pediatric visits; and use Bright Futures *or other* American Academy of Pediatrics recognized developmental and behavioral screening system
- b. Refer patient to PCP for age/developmental assessment, identifying PCP and ensuring closed-loop referral guidelines are followed
- c. PCP provider completes age/developmental assessment; makes referral to appropriate provider as indicated
- d. Refer to [Pediatric Development Pathways](#).

### 3. Referral Pathways Table

Domain	Question	Potential Pathways
3.1 Medical	<a href="#">Does your child see his/her doctor at least once a year for a physical or well care visit?</a>	<ul style="list-style-type: none"> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• Lamprey Health Care</li> <li>• St. Joseph Hospital &amp; Physician Practices</li> <li>• MCO Provider Search Directory</li> <li>• City of Nashua Public Health (immunizations)</li> </ul>
	<a href="#">Has your child had an emergency room (ED) visit in the last 90 days?</a>	<ul style="list-style-type: none"> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• Lamprey Health Care</li> <li>• St. Joseph Hospital &amp; Physician Practices</li> <li>• GNMHC - Community Council</li> <li>• MCO Provider Search Directory</li> </ul>
	<a href="#">Does your child exercise or play sports that make him/her sweat or breathe hard for 30 minutes at least 3 times per week</a>	<ul style="list-style-type: none"> <li>• YMCA</li> </ul>
3.2 Education and Health Literacy	<a href="#">Is your child enrolled in school?</a>	<ul style="list-style-type: none"> <li>• School System</li> <li>• Nashua Public Library</li> <li>• The Youth Council</li> </ul>
	<a href="#">What is the highest level of school you have finished?</a>	<ul style="list-style-type: none"> <li>• School System</li> <li>• Adult Learning Center (potential IDN member)</li> <li>• Nashua Public Library</li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• Southern NH Services</li> <li>• Granite State Independent Living</li> <li>• Teach Back: <a href="http://www.teachbacktraining.org">http://www.teachbacktraining.org</a></li> <li>• SNH Services</li> </ul>
3.3 Employment and Entitlement	<a href="#">Do you have health insurance?</a>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• Department of Health, Human Services (DHHS)</li> <li>• NH Insurance Department: <a href="https://www.nh.gov/insurance/consumers/mp_plans.htm">https://www.nh.gov/insurance/consumers/mp_plans.htm</a></li> <li>• NH 211</li> </ul>
	<a href="#">Does your child hold a job?</a>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> </ul>

		<ul style="list-style-type: none"> <li>• ESL (English as a Second Language) classes</li> <li>• NH Employment Security</li> <li>• Health Profession Opportunity Project (HPOP)</li> <li>• NH 211</li> </ul>
3.4 Housing	<a href="#">What is your housing situation for your child today?</a>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• Harbor Homes</li> <li>• Southern NH Services</li> <li>• The Front Door Agency</li> <li>• Nashua Welfare Department</li> <li>• NH Housing Authority</li> <li>• NH 211</li> </ul>
3.5 Functional Status and ADL/IADL	<a href="#">Are you currently having issues at home with your utilities such as your heat, electric, natural gas or water?</a>	<ul style="list-style-type: none"> <li>• SNH Services – Fuel Assistance</li> <li>• Nashua Welfare Department</li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> </ul>
	<a href="#">Do you/your family worry about whether your food will run out and you won't be able to get more?</a>	<ul style="list-style-type: none"> <li>• St. Joseph Community Services</li> <li>• Nashua Soup Kitchen</li> <li>• Department of Health, Human Services (DHHS)</li> <li>• WIC Program</li> <li>• Nashua Welfare Department</li> <li>• Aunt Bertha: <a href="https://www.auntbertha.com/">https://www.auntbertha.com/</a></li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• NH 211</li> </ul>
	<a href="#">In past 12 months, has lack of transportation kept you from keeping your child's medical appointments, meetings, or from getting things needed for daily living?</a>	<ul style="list-style-type: none"> <li>• Nashua Welfare Department</li> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• NH Medicaid Coordinated Transportation Solutions (CTS): <a href="http://www.ctstransit.com">www.ctstransit.com</a>;</li> <li>• MCO Approved Transportation</li> <li>• Aunt Bertha: <a href="https://www.auntbertha.com/">https://www.auntbertha.com/</a></li> <li>• Local Public Transportation</li> </ul>
	<a href="#">In the past 12 months, how hard is it for you to pay for your child's medical care and medications?</a>	<ul style="list-style-type: none"> <li>• DHHS</li> </ul>
	<a href="#">Does your child need assistance with any of the following tasks - ADLs?</a>	<ul style="list-style-type: none"> <li>• Gateways Community Services</li> <li>• MCO Home Health Care Services</li> </ul>

3.6 Family and Support Services	<a href="#">How often does your child see or talk to people that they care about and feel close to?</a>	<ul style="list-style-type: none"> <li>• GNMHC – WRAAPs program</li> <li>• Local Family Support Groups</li> <li>• NAMI NH</li> </ul>
	<a href="#">How often does your child appear isolated from others?</a>	<ul style="list-style-type: none"> <li>• GNMHC – WRAAPs program</li> <li>• Local Family Support Groups</li> <li>• NAMI NH</li> </ul>
3.7 Legal	<a href="#">Do you or your child have any legal issues that are getting in the way of your health or well-being of your child?</a>	<ul style="list-style-type: none"> <li>• Ascentria Care Alliance (Refugees &amp; New Immigrants)</li> <li>• NH Legal Aid</li> <li>• Nashua Public Defender’s Office &amp; other Legal Services: <a href="https://www.nashuanh.gov/820/Legal-Contacts">https://www.nashuanh.gov/820/Legal-Contacts</a></li> <li>• NH 211</li> </ul>
3.8 Depression	<a href="#">Little interest or pleasure in doing things?</a>	<ul style="list-style-type: none"> <li>• The Youth Council</li> <li>• Lamprey Health Care</li> <li>• GNMHC - Community Council (Links under “Services” &amp; “Resources”)</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• NAMI NH</li> </ul>
	<a href="#">Feeling down, depressed, or hopeless?</a>	
3.9 Substance Use (Illegal Drug Use)	<a href="#">Smoke any marijuana or hashish?</a>	<ul style="list-style-type: none"> <li>• GNMHC</li> <li>• The Youth Council</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• St. Joseph Hospital &amp; Physician Practices</li> <li>• Nashua Dept. of Public Health Community Connections Guide to Recovery: <a href="https://www.nashuanh.gov/DocumentCenter/View/11231/Guide-to-Recovery-PDF">https://www.nashuanh.gov/DocumentCenter/View/11231/Guide-to-Recovery-PDF</a></li> </ul>
	<a href="#">Use anything else to get high? (includes illegal drugs, over the counter and prescription drugs, and anything that can be “sniffed” or “huffed”, etc.)</a>	
3.10 Substance Use (Alcohol)	<a href="#">Drink any alcohol (more than a few sips)? (Do not count sips or alcohol taken during family or religious events)</a>	<ul style="list-style-type: none"> <li>• GNMHC</li> <li>• The Youth Council</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• St. Joseph Hospital &amp; Physician Practices</li> <li>• Nashua Dept. of Public Health Community Connections Guide to Recovery: <a href="https://www.nashuanh.gov/DocumentCenter/View/11231/Guide-to-Recovery-PDF">https://www.nashuanh.gov/DocumentCenter/View/11231/Guide-to-Recovery-PDF</a></li> </ul>

<p>3.11 Substance Use (Tobacco Use)</p>	<p><u><a href="#">Use any tobacco products? (includes cigarettes, chewing tobacco, snuffs, dissolvable, vapor cigarettes, any smokeless tobacco products, etc.)</a></u></p>	<ul style="list-style-type: none"> <li>• GNMHC</li> <li>• The Youth Council</li> <li>• YMCA – Tobacco cessation programs</li> <li>• QuitNow NH 1-800-QUIT-NOW</li> <li>• US DHHS Agency for Healthcare Research &amp; Quality: <a href="https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/index.html">https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/index.html</a></li> </ul>
<p>3.12 Risk Assessment (Physical Safety)</p>	<p><u><a href="#">Does your child feel physically and emotionally safe where you currently live?</a></u></p>	<ul style="list-style-type: none"> <li>• GNMHC</li> <li>• The Youth Council</li> <li>• Dartmouth Hitchcock</li> <li>• Foundation Medical Partners</li> <li>• St. Joseph Hospital &amp; Physician Practices</li> <li>• Bridges</li> </ul>
<p>3.13 Risk Assessment (Suicide Risk)</p>	<p><u><a href="#">Thoughts of suicide, feelings that he/she would be better off dead, or have thoughts of harming him/herself in some way?</a></u></p>	<ul style="list-style-type: none"> <li>• GNMHC - Community Council</li> <li>• Harbor Homes</li> <li>• NAMI NH</li> <li>• SNHMC</li> <li>• SNHMC ED/Access Team</li> <li>• St. Joseph Hospital ED</li> </ul>
<p>3.14 Pediatric Development</p>	<p><u><a href="#">Do you have any concerns related to your child's development in the following areas</a></u></p>	<ul style="list-style-type: none"> <li>• Dartmouth Hitchcock - Pediatrics</li> <li>• Foundation Medical Partners - Peds</li> <li>• Lamprey Health Care - Peds</li> <li>• St. Joseph Primary Care Practice Network for Pediatrics</li> </ul>

## Appendix - Glossary

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**American Academy of Family Physicians (AAFP)** – The American Academy of Family Physicians was founded in 1947 to promote the science and art of family medicine. It is one of the largest medical organizations in the United States, with over 131,400 members. The AAFP was instrumental in establishing family medicine as a recognized medical specialty; a certifying board was approved by the [American Board of Medical Specialties](#) in 1969. The AAFP is headquartered in [Leawood, Kansas](#).

**Assessment Measures (Assess\_Screen.x)** – Clinical outcome measures are used by the NH DSRIP (Delivery System Reform Incentive Payment) program to evaluate Integrated Delivery Network (IDN) performance for incentive payment. These measures are part of CMS approved protocols (and hence the IDN contracts) and also allow the Department (NH Department of Health and Human Services) to support DSRIP oversight and evaluate overall program impact.

**Attributed Population** – Every NH Medicaid beneficiary is attributable to one (and only one) IDN for the basis of the DSRIP demonstration funding formula and for the measurement of performance metrics for each IDN. The principle of the attribution methodology is that beneficiaries should be attributed to IDNs based upon where they currently receive their care, however, that is not always possible to identify, so attribution is based upon four factors: 1) use of long-term care facility providers, 2) use of mental health/substance use disorder providers (including Community Mental Health Center) providers, 3) use of primary care providers, 4) geographic criteria (when necessary).

**Behavioral Health Population** – DHHS determined subset of the Medicaid population that is broadly likely using, at risk for, or in need of behavioral health care.

**Behavioral Health** – Behavioral health includes mental health services as well as Substance Use Disorder (SUD) services.

**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. The assessment is intended to be a standardized screening process that integrates medical, behavioral and social needs and results in the identification of needs with appropriate referrals and linkages. Standardization results from the screening of a core set of domain areas. The IDN is required to develop and implement CCSA protocols that detail the requirements for the assessment process, documentation, expectations of providers and training plan, tools used, and referral process for assessment findings and individual needs.

**CIHS** - SAMHSA-HRSA Center for Integrated Health Solutions which is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care

**CIHS’ Standard Six-Level Framework for Levels of Integrated Healthcare Model** - promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions

**DHHS** – Department of Health and Human Services.

**Direct Secure Messaging (DSM)** – The ability to transmit protected health information (PHI) between providers which includes secure sharing of documents related to information sharing and care coordination.

**DSRIP** - Delivery System Reform Incentive Payment is a vehicle for states to improve health outcomes and population health by reforming the health care delivery system to be more effective in addressing both physical and behavior health for the Medicaid population.

**Electronic health record (EHR) or other electronic tracking system** – For the purposes of this document, an Electronic Health Record or other electronic tracking system, includes a treatment provider's medical record system (e.g., Epic, GE Centricity), a platform that allows IDN member entities to store or query data, or the IDN's reporting service, MAeHC.

**Event Notification Service (ENS)** – Allows providers to receive notifications through an automated service that provides timely alert messages when patients are discharged from a hospital or emergency department.

**Integrated Delivery Network (IDN)** - The provider networks that form regional coalitions and collectively pool funds as a single region, based upon attributed population.

**Institute for Healthcare Improvement and National Patient Safety Foundation (IHI and NPSF)** – These two organizations both out of the Boston, MA area, joined forces to become one organization as of May 1, 2017. NPSF is known for its thought leadership and research on patient safety, while IHI is a considered a leader in redesigning healthcare to be safer and more efficient. This document references a specific study by this organization, "Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era", published in 2017.

**IDN's Medicaid Billing Provider** – A provider who accepts NH Medicaid as part of the IDN.

**Medicaid Population** – For the purpose of DSRIP demonstration, the Medicaid population includes those NH residents enrolled in a Medicaid Managed Organization (NH Healthy Families or WellSense), a Qualified Health Plan as part of NH's premium assistance program (Ambetter commercial plan with PAP indicator, Anthem commercial plan with PAP in group name, Harvard Pilgrim commercial plan with PAP in group name, or Minuteman commercial plan with PAP in group name, which is plan sunsetting 12/31/17) or a Medicaid Fee for Service (FFS) plan, regardless of whether the person also has coverage from another source (e.g., Medicare, commercial insurance).

**Myers and Stauffer, LC (MSLC)** – Myers and Stauffer provides professional accounting, consulting, data management and analysis services to state and federal agencies managing government-sponsored health care programs. They have been contracted by NH DHHS to facilitate the sharing of best practices and lessons learned to support Integrated Delivery Network (IDN) project implementation and attainment of the state's overall waiver goals.

**Shared Care Plan (SCP)** – An electronic tool for information sharing between providers for case management and treatment plan implementation across a Multi-Disciplinary Core Team.

**Special Terms and Conditions (STC's)** - Special Terms and Conditions enable the State of NH (and the IDNs) to operate the demonstration, setting forth the nature, character, and extent of federal involvement in the demonstration and are approved through December 31, 2020

**USPSTF** – U.S. Preventive Services Task Force is an independent panel (appointed by a federal agency) of national experts in disease prevention and evidence-based medicine that works to improve the health of the population by making evidence-based recommendations about clinical preventive service.

DRAFT



Add IDN partner logo here

## **NOTICE TO MEDICAID PATIENTS:**

[Enter IDN partner entity name here] is participating in New Hampshire's *Building Capacity for Transformation* 1115 Medicaid Waiver. The program is led by an Integrated Delivery Network. An Integrated Delivery Network is a group of doctors, hospitals, mental and behavioral health providers, and multiple community-based social service organizations who partner to provide better, coordinated care for you.

### **You Can Still Choose Any Doctor or Hospital**

Your Medicaid benefits are not changing. You still have the right to use any doctor or hospital that accepts Medicaid, at any time. Your doctor may recommend that you see particular doctors or healthcare providers, but it is always your choice about what doctors and providers you use or hospitals you visit.

### **Having Your Health Information Gives Us a More Complete Picture of Your Health**

To help your health care providers give you better, coordinated care, Medicaid will share information with us about your care. Your health information will also be shared via a health information exchange (HIE) with other care providers and with your consent, with community-based social service organizations, who will partner in your care. The health information shared will include things like dates and times you visited a doctor or hospital, your medical conditions, and care plans.

This health information from other healthcare providers will give your provider and other healthcare provider in the Integrated Delivery Network a more complete and up-to-date picture of your health.

### **Your Privacy is Very Important to Us**

Integrated Delivery Network providers and community-based partners must put important safeguards in place to make sure all your health care information is safe. Medicaid does not allow you to opt out. If you have questions or need more information about this notice as it relates to your privacy, please contact:

IDN Partner Organization  
Privacy Officer  
Street Address  
City, State, Zip  
Phone: (XXX)XXX-XXXX



## Prescribing Opioids for the Management or Treatment of Pain Checklist

### NOT FOR MEDICAL RECORD

*Excludes cancer and terminal pain and does not apply to the supervised administration of opioids in a health care setting.*

#### For ALL Pain (Acute and Chronic)

- Documented history and physical
- Complete Board approved risk assessment tool to determine patient appropriateness for opioids
- Treatment Plan includes consideration of nonpharmacological modalities and non-opioid options for pain
- Lowest effective dose for fewest number of days
- Informed Consent outlining risks and benefits of opioid use
- Query the NH PDMP\* (Prescription Drug Monitoring Program) Initial script: \_\_\_\_\_ (date)
- Prescriber may want to print the PDMP query results/screen shot for the medical record*

\*Exceptions for PDMP use: Controlled Rx *administered* to patient; PDMP inaccessible due to electronic issue; or ED with high patient volume such that querying the PDMP would create a delay in care.

#### Acute Pain

- Document opioid prescription and rationale
- Prescription limited to 7 days when issued in emergency dept., urgent care or walk-in clinic
- For unresolved acute pain where continuity of care is anticipated: No obligation to prescribe opioids for more than 30 days; however, if unresolved acute pain persists beyond 30 days, requires an in-office, follow-up appointment \_\_\_\_\_ prior to issuing a new script.

**NH RSA 318-B:41** Rulemaking for Prescribing Controlled Drugs

**Administrative Rules Med 502** Opioid Prescribing



Southern New Hampshire  
**Medical Center**

Patient ID

## Opioid Risk Assessment Tool

New Hampshire Board of Medicine Rule 502.04(f) requires prescribing licensees to complete this risk assessment tool for patients prior to prescribing opioids for acute pain management.

Low Risk Score = 0 to 3  
Moderate Risk Score = 4 to 7  
High Risk Score =  $\geq 8$

Circle each box that applies	Female	Male
<b>Family history of substance abuse</b>		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
<b>Personal history of substance abuse</b>		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
<b>Age between 16—45 years</b>	1	1
<b>History of preadolescent sexual abuse</b>	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
<b>Scoring totals</b>		

Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time:

Developed from the New Hampshire Board of Medicine approved form published with the permission of Lynn R. Webster, MD (2005)





## CONSENT FOR TREATMENT WITH NARCOTICS

Treatment with narcotics (opioids), such as morphine, oxycontin, or others can be helpful in addressing pain. Opioids do not “cure” pain conditions. The goal (benefit) of this therapy is to relieve pain, improve functioning during the day and improve sleep. The most common risks of this treatment are:

- Physical addiction (withdrawal symptoms such as abdominal cramping, anxiety, “goose flesh”, diarrhea, tremors, runny nose, itching and others on stopping these drugs) or psychological dependence (craving)
- Overdose resulting in death
- Nausea, vomiting, constipation, decreased appetite
- Impaired thinking ability, sleepiness and confusion
- Allergic reactions,
- Breathing problems
- Dizziness
- Increased sensitivity to pain
- Problems with coordination or judgment that may make it unsafe to drive a motor vehicle or dangerous equipment
- Development of tolerance (larger doses needed to achieve the same effect)
- Taking alcohol or other medication not approved your provider while taking narcotics could be extremely dangerous
- You could be become the target of a crime by those who may seek to steal these medications

I have read and understand the above information including the risks and benefits of opioid use and have had the opportunity to have any questions answered to my satisfaction. I agree to the use of opioids to help control my pain.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time:

Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time:



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
	Electronic CCSA	Collective Medical ENS/SCP	DSM & Integrated DSM (Part of EHR)	Collective Medical ENS/SCP	DSM & Integrated DSM (Part of EHR)	Collective Medical ENS/SCP	DSM & Integrated DSM (Part of EHR)	Awaiting Kno2 Closed Loop Referral functionality build for this solution
<b>Dartmouth-Hitchcock</b>								
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
<b>Foundation Medical Partners Practices</b>								
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	N	N	N	N	N	N	N
Lamprey Health Care	Y	N	Y	N	Y	N	Y	N
Merrimack River Medical Services	N	N	Y	N	Y	N	Y	N
<b>St. Joseph Hospital Practices</b>								
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)	N (see Note 3)	N (see Note 3)	N (see Note 3)	N (see Note 3)	N (see Note 3)	N
The Youth Council	N (see Note 2)	N (see Note 3)	N (see Note 3)	N (see Note 3)	N (see Note 3)	N (see Note 3)	N (see Note 3)	N
<b>Notes:</b>								
1. DH has contracted with CMT for all their practices but Nashua Practices have not completed workplans for CMT								
2. Using Paper Version of CCSA								
3. In progress - expect in Q1 of 2019								

## ***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, Timelines, Core Components, Process Milestones, and Evaluation Project 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*

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. In these cases, Gateways Community Services has been contracted through funding from the IDN to provide clinical case management consultation to support the CTI team for those clients experiencing numerous visits to the Emergency Department and meeting the criteria for CTI otherwise. Additionally, for those clients expressing a desire to engage with more spirituality-based therapeutic interventions, The Emmaus Institute has been contracted through funding from the IDN to provide clinical case management consultation and support services.

Other criteria for the CTI target population include those not already connected to a mental health provider and reporting having at least three of the following functional impairments:

- At risk of homelessness or currently homeless
- Lack of positive social support/natural supports network
- Inability to perform activities of daily living adequately
- Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)
- Inability to manage money
- Unemployment/underemployed/lack of employment skills.

**With the CTI program encompassing approximately 9 months per client, the team is projected to reach between 80 and 100 clients annually. Per the program's fidelity, the team is expected to have a caseload of approximately 60 cases at a time, depending upon staffing and the level of intervention clients receive at the time. For example, Phase 3 is less time-intensive than Phase 1.**

**During the reporting period, 29 clients were enrolled in the program, with monthly representation by phase outlined below:**

Phase 1:

- July – September: 16
- October: 6
- November: 2
- December: 3

Phase 2:

- July – September: 7
- October: 9
- November: 17
- December: 14

Phase 3:

- July – September: 3
- October: 11
- November: 2
- December: 5

Graduating:

- July – September: 0
- October: 0
- November: 0
- December: 2

**Workforce: Recruitment/Hiring and Training**

*Progress:*

The CTI team is housed under the umbrella of the Greater Nashua Mental Health Center. At the onset of the program in late 2017, initial **target** staffing for the team included:

- Team Lead (Coordinator): 1 FTE
- Specialist (Case Manager): 2.5 FTEs.

**Based upon lessons learned in the first 6 months of the pilot, the determination was made that there was a need for increased supervision in the field, more staff on the team to allow for capacity in securing client referrals, and back up from a licensed mental health provider to assist with challenging mental health crisis and collaborative efforts with other organizations.**

As a result, the proposed staffing **model** for the team **during the reporting period** included:

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

As of December 2018, the Clinical Supervisor was in place to support the team with the additional capacity and expertise to support the client population and collaboration efforts with IDN providers and other referrals sources. However, due to the **Team Lead/Field Coordinator leaving their position in April 2018, the Clinical Supervisor took on both roles. GNMH immediately began utilizing IDN funds to support**

recruitment/hiring efforts to fill the vacant Team Lead/Coordinator role, as that individual left the position in late April 2018. The two Specialists (on-boarded at the onset of the pilot) remain with the program. The remaining .5 FTE Specialist position continued to be vacant, but was being actively advertised.

The team continued to engage in completing the training outlined in the CTI Training Plan, including participating in IDN funded trainings:

- Advanced Motivational Interviewing (July 2018)
- NH Behavioral Health Summit (December 2018)

Engagement with Hunter College (contracted through IDN funds), continued, with the team engaging in monthly Community of Practice (CoP) calls with the other 4 CTI pilots around the state, increasing their knowledge and building collaboration. Quarterly, the CoP was a longer (3-hour), in-person meeting to allow for guest speakers/experts to attend and provide additional information to support the team's efforts.

Additionally, the team completed its Fidelity Self-Assessment, working one-on-one with Hunter College through individual technical assistance. This baseline will be utilized to develop a Fidelity Action Plan that will allow the team to make progress toward the goal of meeting CTI's evidence-based program fidelity in early 2019 through continued support from the CoP and individual technical assistance provided by Hunter College.

#### ***Barriers and Mitigation Plans to Future Achievement***

One of the barriers to achieving a full caseload is the vacancy of the Team Lead/Field Coordinator and delays in on-boarding the half-time Specialist. To mitigate this, GNMH is utilizing the IDN resources to support sponsored ads and targeted marketing efforts as well as recruitment/hiring incentives, such as sign-on bonuses and staff referral bonuses. The organization is revising the role of the half-time Specialist to consider the possibility of a Peer Support Specialist, rather than a Case Manager.

#### ***Training and Technical Assistance to Achieve Program Fidelity***

During this reporting period, the CTI team engaged in a number of training and technical assistance opportunities to build their knowledge and skills to support the program's strategies. These included:

- Advanced Motivational Interviewing (July 2018)
- NH Behavioral Health Summit (December 2018)
  - Understanding Addiction
  - Co-Occurring Disorders

The team also participated in monthly Community of Practice (CoP) calls with the other 4 IDN regions implementing CTI strategies. While the majority of the 1 hour meetings were via webinar/phone on the 4<sup>th</sup> Friday of the month, with two were held in person as longer (3-hour) sessions.

#### **Development and Implementation of Clinical Services Infrastructure**

##### ***Standardized Assessments and Protocols/Workflows***

The team utilizes the CTI Brief Assessment tool as the standardized assessment tool for the program, in addition to implementing the CCSA process. As a client is referred to the program from one of the hospital referral sources, the CTI Referral Form is utilized, supporting the referring organization as they determine whether or not the client meets the preliminary eligibility criteria for the program. Then, once enrolled, the CCSA process is implemented, which supports the CTI Assessment Tool.

Clients referred to CTI will meet the following criteria:

- ~~A primary serious and persistent mental illness (SPMI)/serious mental illness (SMI) diagnosis.~~
- ~~Is not already connected to care coordination/case management~~
- ~~Has at least three of the following functional impairments:~~
  - ~~At risk of homelessness or is currently homeless~~
  - ~~Lack of positive social support/natural supports network~~
  - ~~Inability to perform activities of daily living adequately~~
  - ~~Lack of basic subsistence needs (food stamps, benefits, medical care, transportation)~~
  - ~~Inability to manage money~~
  - ~~Substance use with negative impact~~
  - ~~Unemployment/underemployed/lack of employment skills.~~

*Referrals into CTI:*

Referrals into CTI are through the use of 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 identifying key criteria for eligibility:

- 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.

*CTI Intake:*

**Clients are referred to the CTI Clinical Supervisor or CTI Team Leader, who completes the CCSA process and engages the CTI Specialist to complete the CTI Brief Assessment with client. 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.

The CTI Specialist then determines appropriateness for the program, referring to Adult Assertive Community Treatment (ACT) Team or other treatment program if deemed to need a higher level of case management and treatment.

### *Treatment and Management*

**The client is provided with intensive case management with a CTI Specialist, who identifies the 3 focus areas and goals mutually agreed upon with the client. This may include:**

- **psychiatric treatment/medication management**
- **substance use treatment**
- **daily living skills training**
- **housing crisis prevention and management**
- **money management**
- **family interventions.**

There is a starting date and a closing date for the end of each phase. Additionally, the 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.

**As part of the pilot, Informal case management meetings have been developed with IDN Member Entities who are part of the care team. These include frequent ongoing meetings with referral sources (e.g., SNHHS BHU) and as-needed meetings with services referred to, such as the First Episode Psychosis (FEP), the Assertive Community Treatment (ACT), Acute Care Services (ACS) and InteGreat Health programs. During the reporting period, a case management meeting with The Emmaus Institute was conducted to support a shared patient/client. To support clinical case consultation, the IDN is providing funds to support The Emmaus Institute and Gateways Community Services to support those patients/clients who may benefit from spirituality services or who may have an intellectual and/or development disability.**

### *Referrals out of CTI*

Throughout Phase II of the CTI model, the CTI Specialist works with the client to make active referrals and ensure follow-through in seeing their primary care physician (or assists them in finding one, if they are lacking one), as well as to a mental health clinician while developing and implementing a transition plan. Emotional support is consistently provided in moving the client toward more self-sufficiency. Client referrals to services deemed necessary for the client to achieve their mutually-agreed upon goals include those members of the IDN who, **as the demonstration evolves and GNMH and other IDN treatment providers building capacity, they will engage in receiving the admission, discharge and transfer (ADT) event notifications through CMT.**

**By early 2019, the goal is to build the capacity and skills to engage in providing care guidelines and engaging in shared care planning (SCP) through the CMT platform. The ability to use direct secure messaging (DSM) to receive and send PHI was in the final stages of completion with Kno2 at the end of the reporting period, with the goal of building interfaces from the ENS/SCP and DSM platforms with the**

existing GNMH Electronic Health Record (EHR). By achieving this, CTI staff will be able to implement closed loop referrals, per the IDN approved protocols/guidelines.

## Evaluation and Program Impact

### *Project Evaluation Targets*

The CTI team, with support from the IDN Clinical Governance Committee and IDN Administrative Lead, has achieved some success in achieving project targets.

Increasing the team's knowledge and skills to work with this complex population with SMI/SPMI was achieved through the team's engagement Hunter College through participating in the monthly Community of Practice (CoP) meetings with the other 4 IDNs implementing the CTI program in their regions and attending the NH Behavioral Health Summit. Through these trainings and educational activities, the team was able to increase their knowledge and skills in the CTI fidelity model screening tools, as well as standard assessment, treatment, management and referral protocols. They were also able to learn more about the available resources in the greater Nashua region, as well as statewide to support the physical and mental health, as well as economic, legal, educational, social, housing and transportation needs of their clients to enable them to work toward self-sufficiency by being able to access these needed services and supports as they transition back to their community and support their recovery.

Additionally, members of the team engaged in trainings that supported increased knowledge and skills, including motivational interviewing training, cultural competency, and care coordination/universal screening. GNMH leadership has provided training to the team on use of the CCSA process and as **ENS/SCP capabilities are finalized in early 2019, will work with the IDN and HIT vendors to train users, implementing workflows for soliciting informed patient consent.** ~~More trainings will be provided to the team as 2018 wraps up, including more focused trainings on the CCSA process, use of the HIT platforms (data aggregation/reporting, ENS/SCP, and DSM), and patient privacy and consent.~~

The outcome evaluation targets for providers are in process, as more engagement of the CTI team with the other client's providers occurs through care coordination and shared care plans. These targets are expected to evolve and become achievable through the identification of key indicators and data sources as well as operationalization of the information sharing platforms and training is completed in early 2019. ~~Agreements and –as we approach the end of 2018 and early 2019 and include increased skills for supporting the transitions of the target sub population from hospital settings to the community and the establishment of formal workflows and protocols between providers, including the hospitals (emergency department and inpatient), will be finalized in early 2019 to better engage the client in transitions of care between inpatient hospitalization and assessments with the Community Mental Health Center (CMHC).~~

Completion of the CTI self-assessment in November (see attached), with a score of 3.73, provided further insights to the team and builds the foundation to continue engaging with Hunter College through one-on-one technical assistance to reach program fidelity. This score indicates the CTI Team well on their way to reaching fidelity.

Finally, as the clients move through the 3 phases of CTI, they are also expected to reach the evaluation targets, including increased skills for:

- engaging in the activities necessary to secure stable housing
- using community-based services available to address daily living needs
- engaging in the activities necessary to secure stable housing

- using supports identified in their crisis management plan to access in situations where they need assistance to avoid going back into emergency department or other inpatient setting.

*Programmatic Outcomes*

The programmatic outcome targets set by GNMHC entail some increased care coordination with providers, enabling clients to have more consistent connections with primary care and mental health care providers, but also behavior changes with the client through seeing reductions in utilization of the emergency departments/inpatient visits, increases in utilization of community-based services (housing assistance, legal assistance, family and support services), as well as client engagement in a stable housing plan. Finally, a systems change target is to see a decrease in “no-shows” for initial appointments upon discharge from acute and inpatient stays through more efficient and effective care coordination and event notification as the CTI strategy becomes more ingrained in the fabric of those referral sources.

To date, the CTI program has received 66 referrals from multiple sources (see below), since its onset in December 2017. Of the 66 referrals, 32 were deemed ineligible, unable to contact after discharge from the referral source, or the client declined to enroll in the service. The remaining 35 were eligible. Three, however, were assessed as needing a higher level of care and were transferred to the Assertive Community Treatment (ACT) Team and GNMHC. To date, 2 clients have graduated.

The referrals to CTI came from the following:

- SNMHC Emergency Department (8)
- SNHMC Behavioral Health Unit (33)
- Acute Care Services (ACS) at GNMHC (3)
- NH Hospital (7)
- Dartmouth Hitchcock Hospital (2)
- the Cypress Center (1)
- The Elliot Hospital Pathways Unit (1)
- Holy Family Hospital (Massachusetts) (1)
- Mobile Crisis Response Team at Harbor Homes (9)
- Parkland (1).

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

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
Client Engagement	Up to 10 clients are engaged in CTI in 2017, depending upon workforce recruitment, training timing and referral protocols being in place.	Progress met: 15 clients are engaged in the CTI strategy	Achieved: 29 clients are currently engaged in the CTI strategy
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.	In progress: 23 clients referred to date, with 10 enrolled and 2 pending enrollment as of the end of the reporting period.	Achieved: 66 referrals to date, with 29 currently enrolled, 2 graduated.

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	Progress met: 1 CTI team member was trained by Hunter College as part of the CTI Staff Training #2 on March 19-20, 2018.	Achieved: 3 CTI staff members were trained by Hunter College as part of the CTI Staff Training.
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.	Progress met: 1 CTI team member was trained by Hunter College as part of the CTI Staff Training #2 on March 19-20, 2018.	Achieved: 3 CTI team members were trained by Hunter College as part of CTI Staff training.
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.	Progress met: 2 CTI team members were trained as part of the CTI Supervisor training.	Achieved: 2 CTI team members were trained as part of 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 Hunter College.	Progress met: All CTI staff engaged in monthly CoP sessions via webinar, as well as the March (Plymouth) and June (Concord) in-person sessions.	Achieved: All CTI staff engaged in monthly CoP sessions via webinar, as well as the August and October 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.	Progress met: All CTI staff have been trained by Hunter College in the CTI Staff training between the November 2017 and March 2018 trainings.	Achieved: All CTI staff have been trained by Hunter College in the CTI Staff training between the November 2017 and March 2018 trainings.

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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 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 was held on the use of the MAeHC data portal in January 2018, no CTI team members participated. Other trainings are expected in the last half of 2018 for MAeHC, CMT and Kno2 to support information sharing and communication.	Not achieved: <del>This is expected to be achieved in early 2019 now that CMT and Kno2 are operational.</del> <b>CMT (ENS/SCP) and Kno2 (DSM) contracting was completed at the end of the reporting period. Staff will be trained by the vendor by April 2019.</b>
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.	In progress: The team is determining the indicators and tracking process for this target.	<del>Not achieved</del> <b>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, however challenges include 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 throughout the next reporting period.</b> <del>This is expected to be completed in early 2019 through training provided by Greater Nashua Mental Health housing and community support staff.</del>
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 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: A case management meeting was held 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.	Achieved: Case management meetings were held with The Emmaus Institute, Life Coping, and Greater Nashua Mental Health Center.

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
Increased skills to engage in the activities necessary to secure stable housing.	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.	<del>In progress:</del> <b>Achieved:</b> All CTI clients who are homeless upon referral to CTI complete a housing plan. However, housing vacancy rates in Nashua make obtaining housing challenging. Shelters are full, one shelter in the city is no longer accepting referrals as they have changed their focus, and every program has a waitlist. GNMH will continue to work with shelters to house clients as they await housing plans . All CTI clients have a housing section in their Phase Plan.
Increase in the use of supports identified in the client's crisis management plan to utilize in situations where they need assistance.	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: 13 incidents since CTI began of ED or hospital readmission, but GNMH has been unable to determine if this is change to baseline. Anecdotally, 1 person had 3 admissions, each in a different facility, from June and July of 2018, for the same episode of treatment, so the operationalization of the event notification service (ENS) and shared care plan (SCP) platforms will be useful moving forward.
Establishment of formal workflows and protocols between providers that engages the client in transitions of care between inpatient hospitalization and assessments with the Community Mental Health Center (CMHC).		In progress: The team is determining the indicators and tracking process for this target.	Achieved: Releases of information (ROI) are executed with every client, allowing CTI staff to facilitate the exchange of information between providers and ensure clients arrive at their appointments (for as long as the client permits).

### ~~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
Master's Level Licensed Clinical Supervisor	2	0	1	2	2
CTI Field Coordinator	1	0	1	0	0
Bachelor's Level CTI Specialist (Case Manager)	2.5	0	2	2	2
Community Health Worker	8	40	40	42	42
Recovery/Transitional Care Case Manager	1	.5	0	.5	.5

### 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
Licensed Therapist	1.15	0	1	1	1
Case Manager	2.5	0	1	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, as outlined in the C-4a Budget Table below.

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): \$78,580.18

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$78,580.18
  - Jan – June 2018 actuals: \$46,188.00
  - July – December 2018 actuals: \$32,392.18

Projections are displayed for the July to December 2018, as well as 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 (Licensed Therapist)**
- **Specialist: 2.5 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. 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.~~

Expenditures reflected in the budget table below reflect the following:

Employee salary/wages to support:

- Team Lead/Coordinator: 1 FTE (Licensed Therapist)
- Specialist: 2.5 FTE (Case Manager)

Consultants:

- Interpreter services for 41 clients

Equipment to support staff under Salary/Wages:

- Laptops and desktops

Supplies:

- Medical/lab/pharmacy
  - Rental assistance for 1 client
  - Client medication for 1 client
  - Client gift cards for use across multiple clients

Travel:

- Mileage for CTI Specialists (2 FTEs)

Current expenses to support staff under Salary/Wages:

- Telephones for CTI Specialists (2 FTEs)

Other (Indirect costs):

- Capped at 21% per IDN 3 Finance Governance Committee

## C.4a: IDN Community Project

### Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	Jan-June 2018 Actuals	July-Dec 2018 Projected	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	\$597,808.00	\$0.00	\$0.00	\$33,783.00	\$94,004.17	\$24,844.61	\$215,672.16	\$215,672.16	\$107,836.08	\$597,808.00
Employee Benefits	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Consultants	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Equipment	\$30,200.00	\$0.00	\$0.00	\$0.00	\$5,003.33	\$0.00	\$12,080.00	\$12,080.00	\$6,040.00	\$30,200.00
Supplies (sum of lines below)	\$3,776.00	\$0.00	\$0.00	\$3,776.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$3,776.00
Educational		\$0.00	\$0.00	\$0.00						\$0.00
Medical/Lab/Pharmacy		\$0.00	\$0.00	\$0.00						\$0.00
Office	\$3,776.00	\$0.00	\$0.00	\$3,776.00						\$3,776.00
Travel (mileage/parking expenses)	\$19,093.31	\$0.00	\$0.00	\$207.00	\$3,147.72	\$1,403.90	\$6,992.96	\$6,992.96	\$3,496.48	\$19,093.31
Occupancy	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Current Expenses (sum of lines below)	\$406.00	\$0.00	\$0.00	\$406.00	\$0.00	\$522.63	-\$209.05	-\$209.05	-\$104.53	\$406.00
Telephone	\$406.00	\$0.00	\$0.00	\$406.00		\$402.95				\$808.95
Internet costs		\$0.00	\$0.00	\$0.00						\$0.00
Postage		\$0.00	\$0.00	\$0.00						\$0.00
Printing and Copying		\$0.00	\$0.00	\$0.00		\$119.68				\$119.68
Audit and Legal		\$0.00	\$0.00	\$0.00						\$0.00
Insurance		\$0.00	\$0.00	\$0.00						\$0.00
Board Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Software	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Marketing/Communications	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Staff Education and Training	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Subcontracts/Agreements	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other (specific details mandatory):	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Recruitment Fees		\$0.00	\$0.00	\$0.00						\$0.00
Sign-on Bonus		\$0.00	\$0.00	\$0.00						\$0.00
Staff Referral Bonuses		\$0.00	\$0.00	\$0.00						\$0.00
Relocation Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Student Loan Repayment/Reimbursement		\$0.00	\$0.00	\$0.00						\$0.00
Employee Recognition/Retention Bonus		\$0.00	\$0.00	\$0.00						\$0.00
CMEs/Professional Development		\$0.00	\$0.00	\$0.00						\$0.00
Professional Development Fees/Dues		\$0.00	\$0.00	\$0.00						\$0.00
Staff Licensing/Certification Supervision Stipend		\$0.00	\$0.00	\$0.00						\$0.00
Other: please specify below	\$137,128.59	\$0.00	\$0.00	\$8,016.00	\$21,518.77	\$5,621.04	\$49,396.62	\$49,396.62	\$24,698.31	\$137,128.59
<b>TOTAL</b>	<b>\$788,411.90</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$46,188.00</b>	<b>\$123,673.99</b>	<b>\$32,392.18</b>	<b>\$283,932.69</b>	<b>\$283,932.69</b>	<b>\$141,966.34</b>	<b>\$788,411.90</b>

## 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 Kno2 or Integrated direct secure messaging platform within EHR) to GNMHC, with referring provider organization utilizing IDN recommended guidelines/protocols for closed loop referral.	Current

Protocol Name	Brief Description	Use (Current/Under development)
Screening/Assessment	CTI Case Management Assessment Tool - Upon receipt of CTI Referral Form (received via Direct Secure Message, using Kno2 or Integrated Direct Secure Message, as applicable and available between referring provider organization and CTI team), 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

Protocol Name	Brief Description	Use (Current/Under development)
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 for the 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				

## ***IDN Community Project: Attachments***

attachment\_C.1a: IDN Community Project: Core Components, Process Milestones, Training and Evaluation Project Plans

attachment\_C.9a: Critical Time Intervention (CTI) Training Plan

**attachment\_C1a:**  
**CTI Timeline, Key Milestones and Evaluation Project Targets**

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	A. Get final training budget from Hunter College	
Complete	B. Review with Clinical Committee	
Complete	C. Present to Finance Committee for approval	
Complete	D. Present to Executive Committee for approval	
Complete	E. Budget approved	
Complete	III. Develop workforce plan	
Complete	A. Develop CTI staffing plan	
Complete	B. Develop recruitment and retention strategies	
Complete	III. Identify projected annual client engagement volumes	
Complete	A. Solicit input from IDN project partners across the state and Hunter College/CACTI	
Complete	B. Develop projections	
Complete	IV. Identify key organizational/provider participants	
Complete	A. Greater Nashua Mental Health Center	
Complete	B. St. Joseph Hospital	
Complete	C. Southern NH Medical Center	
Complete	D. New Hampshire Hospital	
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	A. Develop educational tools for partners and relevant stakeholders to identify eligible patients	
Complete	B. Develop criteria for patient eligibility	
Complete	C. Develop standardized care transition plan	
Complete	D. Develop/identify CTI screening/assessment tools, workflows and protocols for CTI phases for case worker guidelines	
Complete	E. Develop case worker guidelines for assessment, treatment, management and referral protocols and workflows	
Complete	II. Identify/develop roles and responsibilities for CTI team members	
Complete	III. Develop CTI team training plan	
Complete	A. Identify curricula/training partner--Hunter College/CACTI	
Complete	B. Develop training and support schedule	
Complete	C. Finalize training and support schedule	
Complete	IV. Identify training curricula	
Complete	V. Develop agreements with collaborating organizations	
Complete	A. IDN sub-contract with Greater Nashua Mental Health Center	
Complete	VI. Develop evaluation plan	
Complete	A. Identify CTI target process and outcome metrics	
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: Collective Medical Technologies (CMT) through PreManage Primary	
Complete	B. GNMHC sets up tracking mechanism in EHR as CMT contracting, policies and protocols are completed	
In progress	C. GNMHC determines if they will utilize Kno2 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	
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	
In progress	C. Onboard CTI Team members	
Complete	C1. GNMHC Supervisor: Julia t., LCMHC	
Complete	C2: CTI Supervisor (Coordinator): Nancy G., MS	Nancy G. left position in April 2018; Julia T. has taken on role of Team Coordinator in interim until new person is on-boarded (expected in July/August 2018)
In progress	C3. CTI Case Workers (Specialists)	
Complete	CTI Specialist #1: (Ashley M.)	on-boarded in November 2017
Complete	CTI Specialist #2: 1 FTE (Ian O.)	on-boarded in January 2018
In progress	CTI Specialist #3: .5 FTE to be hired	The team is determining the need for this role and what the responsibilities might entail, which could include peer support. Determination will be made by Fall 2018.
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	A1a. CTI team participates in CTI Worker training #1 provided by Hunter College (11.15.17 and 11.16.17)	CTI team participants included CTI Supervisor, CTI Coordinator (on-boarded October 2017) and CTI Specialist (on-boarded November 2017)
Complete	A1b. CTI team participates in CTI Worker training #2 provided by Hunter College (3.19.18 and 3.20.18)	CTI team participants included CTI Specialist (on-boarded in January 2018)
Complete	A2. CTI Supervisor Training	
Complete	A2a. CTI team participated in CTI Supervisor training provided by Hunter College (12.15.17)	CTI team participants included CTI Supervisor and CTI Coordinator (on-boarded in October 2017)
Complete	A3. Motivational Interviewing Training	

**attachment\_C1a:**  
**CTI Timeline, Key Milestones and Evaluation Project Targets**

<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
Complete	A3a. CTI team participates in 2-day Motivational Interviewing training provided by Peter Fifield (3.26.18 and 4.2.18)	CTI team participants included the entire team (Supervisor, Coordinator, 2 Specialists)
In progress	A3b. CTI team participates in 1-day Advanced Motivational Interviewing training provided by Peter Fifield (7.30.18)	
In progress	<b>B. Train CTI staff in core competencies for multi-disciplinary core team (MDCT) members</b>	
In progress	<b>B1. Team members participate in multi-disciplinary core team (MDCT) training on HIPAA, Safe Sharing of Protected Health Information and 42 CFR Part 2</b>	
Complete	B1a. HIPAA and Secure Data Sharing training: staff trained in overview of HIPAA and how to secure store PHI data, provided by the IDN (3.19.18 and 3.30.18)	This training was held, but no members of the CTI team participated. More training opportunities will be available by the end of 2018.
In progress	B1b. 42 CFR Part 2 and Protection of Sensitive Health Information: staff trained in the regulations and consent process	expected to be completed by December 31, 2018
In progress	<b>B2. Team members participate in multi-disciplinary core team (MDCT) training the use of IDN HIT Platforms to support information sharing and care coordination</b>	
Complete	B2a. MAeHC manual portal training: staff trained in what the MAeHC platform will be utilized for and preliminary look at the manual data input portal (1.4.18 and 1.8.18)	This training was held, but no members of the CTI team participated. More training opportunities will be available by the end of 2018.
In progress	B2b. MAeHC manual portal training: staff trained in use of the manual data portal, as well as the patient dashboard	expected to be completed by December 31, 2018
In progress	B2c. CMT ENS and SCP training: staff trained in workflows and IDN protocols/guidelines	expected to be completed by December 31, 2018
	B2d. Kno2 Direct Secure Messaging training: staff trained in workflows and IDN protocols/guidelines	expected to be completed by December 31, 2018
Not started	<b>B3. Team members participate in multi-disciplinary core team (MDCT) training on the CCSA and universal screening</b>	
Complete	B3a. DH CSA and social determinants of health pathways learning session: staff educated about DH use of tools and questions, as well as pathways to address patient needs in multiple domains (3.19.18)	CTI team participant included Coordinator
In progress	B3b. CCSA process and IDN protocols/guidelines: staff trained in CCSA tool to be utilized by GNMHC and IDN protocols/guidelines related to universal screening and positive screening pathways	expected to be completed by December 31, 2018
Complete	<b>B4. Team members participate in multi-disciplinary core team (MDCT) training on cultural competency and adaptation</b>	
Complete	B4a. Unpacking Assumptions: staff trained in understanding their own assumptions through use of case examples, including some potential ways to mitigate those assumptions (3.23.18)	CTI team participant included Supervisor
Complete	B4b. Stigma Across Cultures: staff trained in understanding the stigma that exists with behavioral health and how it might impact different cultures in the IDN region differently (5.3.18)	CTI team participant included Coordinator
In progress	B4c. Cultural competency training: staff educated about the various cultures in the greater IDN region as well as build knowledge/skills to support their health and social service support needs	expected to be completed by December 31, 2018
In progress	<b>B5. Team members participate in multi-disciplinary core team (MDCT) training on care planning and care coordination</b>	
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
Not started	<b>B6. Team members participate in multi-disciplinary core team (MDCT) training on co-occurring disorders</b>	
Complete	B6a. Co-occurring disorders training (SUD and Mental Health Conditions): staff educated about the co-occurring nature of mental health and substance use disorders among target sub-population in the IDN provided by NH Healthy Families 6.22.18	This training was held, but no members of the CTI team participated. More training opportunities will be available by the end of 2018.
In progress	B6b. Co-occurring disorders training (Medical and Behavioral Health Conditions): staff educated about the co-occurring nature of medical and behavioral health conditions among target sub-population in the IDN	expected to be completed by December 31, 2018
In progress	B6c. Co-occurring disorders training (SUD and Mental Health Conditions): staff educated about the co-occurring nature of mental health and substance use disorders among target sub-population in the IDN	expected to be completed by December 31, 2018
In progress	<b>B8. Team members participate in multi-disciplinary core team (MDCT) training on understanding addiction</b>	Initial Training on Addiction scheduled for 5.10.18
Complete	B8a. Dual Diagnosis Capability Program Leader Training: staff trained in the Dual Diagnosis Capability (DDC) indices and the planning and implementation processes associated with each, learning about the implications of the DDC indices for supervising improved treatment strategies and models of care for individuals with co occurring mental illness and substance use disorders provided by Case Western Reserve University 1.30.18 and 1.31.18	CTI team participant included Supervisor
Complete	B8b. Initial Training on Addiction and Recovery: staff are educated about the key neurological process of addiction, how addiction manifests in various aspects of the whole person and the stages of change provided by BDAS on 5.10.18	CTI team participant included Supervisor
In progress	B8c. Understanding addiction training: staff educated about how addiction occurs and how it may be part of the complex care needs of their target sub-population	expected to be completed by December 31, 2018
In progress	<b>C. Engage CTI team in statewide CTI Community of Practice (CoP) facilitated by Hunter College</b>	
In progress	<b>C1 Participate in monthly webinar/phone CoP calls</b>	
Complete	December 2017 (12.20.17)	All members of the CTI team participated in this call
Complete	January 2018 (1.23.18)	All members of the CTI team participated in this call
Complete	February 2018 (2.28.18)	All members of the CTI team participated in this call
Complete	April 2018 (4.25.18)	All members of the CTI team participated in this call
Complete	May 2018 (5.23.18)	All members of the CTI team participated in this call
Not started	July 2018	All members of the CTI team participated in this call
Not started	August 2018	
Not started	October 2018	
Not started	November 2018	
In progress	<b>C2. Participate in quarterly in-person CoP meetings</b>	
Complete	March 2018 (3.21.18)	All members of the CTI team participated in this face-to-face meeting, featuring NH Hospital as the guest speaker
Complete	June 2018 (6.27.18)	All members of the CTI team participated in this face-to-face meeting, featuring an overview of the role of CMHCs and data sharing rules for 42 CFR Part 2
Not started	September 2018	

**attachment\_C1a:**  
**CTI Timeline, Key Milestones and Evaluation Project Targets**

<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
Not started	December 2018	
In progress	D. Engage CTI team in one-on-one implementation coaching with Hunter College	up to 5 hours allocated in IDN budget
Complete	One-on-one coaching provided in December 2017	CTI team engaged with Kim Livingstone to review referral form and workflows
Complete	One-on-one coaching provided in February 2018 (2.21.18)	CTI team engaged with Kim Livingstone to review cases and protocols/workflows
In progress	E. Build sustainability of model through providing train-the-trainer training conducted by Hunter College	
In progress	E1. Training targeted for trainers of future CTI staff provided by Hunter College	scheduled for August 23 and 24 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	
Complete	A1. Conduct CTI workflow team planning session with Privacy Work Team	
Complete	A2. GNMHC and IDN Admin Lead Team have meeting to discuss IDN policies and protocols as well as tools and training for patient consent	
Complete	A3. Implement informed consent policies and protocols with CTI patients	GNMHC will utilize existing tools and protocols, which will be shared with the IDN. The IDN is also developing template tools for informed consent.
In progress	B. Implement education, workflows and protocols for patient identification criteria with referral partners	
Complete	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	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 Hunter College	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 Kno2/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 Kno2 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 CMT Shared Care Plan platform with referral information, if applicable	Currently being developed as part of contracting with CMT 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 CMT (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 approval	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 discussions are conducted with Clinical Committee
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 discussions are conducted with Clinical Committee

**attachment\_C1a:**  
**CTI Timeline, Key Milestones and Evaluation Project Targets**

<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
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 discussions 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	
Complete	A1. Implementation of internal tracking tools and mechanisms for case management meetings and supervision to ensure fidelity	Currently in use
Complete	A1a. Implementation of patient tracking spreadsheet for patients enrolled in CTI and for tracking those not enrolled for closed-loop referrals	Currently in use
Complete	A1b. Implementation of caseload review tool for supervision and case management	Currently in use
Complete	A1c. Implementation of CTI Specialist supervision form for case management and monitoring of program fidelity	Currently in use
In progress	B. Implementation of Kno2 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 Kno2	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 CMT for tracking and monitoring	
In progress	C1. GNMHC completes Master Services Agreement and Business Associate Agreement (BAA) directly with CMT (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 CMT 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 CMT 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	<b>Stage 2: Project Utilization Milestones (Initiation of Data Reporting) July to December 2017</b>	
Complete	I. Report on number of individuals served (during reporting period and cumulative) vs. projected	
Complete	A. 2 clients referred to date vs. 10 projected	
Complete	II. Report on number of staff recruited and trained (during reporting period and cumulative) vs. reported	
In progress	A. Staff Recruited: 3 (vs. 3.5 target)	
Complete	B. Staff Trained: 13 (vs. 4 target)	
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	<b>Stage 2: Project Utilization Milestones (Ongoing Data Reporting) January to June 2018</b>	
Complete	I. Number of individuals served (during reporting period and cumulative) vs. projected	
Complete	A. 23 clients referred to date, with 10 enrolled and 2 pending enrollment as of the end of the reporting period, with a projection of 24 clients (up to 4 clients per month until reaching fidelity)	
Not started	II. Number of staff recruited and trained (during reporting period and cumulative) vs. projected	
Complete	A. Staff recruited: 3 (vs. 3.5 projected)	CTI Coordinator left position in April 2018, which is temporarily being filled by CTI Supervisor until position is filled, expected by August 2018 and .5 FTE CTI Specialist has not yet been filled due to a determination yet to be made about the role this position should fill. This is expected by Fall 2018.
In progress	B. Staff trained vs. projected target	
Complete	B1. CTI Staff Training provided by Hunter College: 4 trained vs. 3.5 projected	
Complete	B2. CTI Supervisor Training provided by Hunter College: 2 trained vs. 1 projected	
Complete	B3. Motivational Interviewing Training: 4 trained vs. 3.5 projected	
In progress	B4. HIPAA, Safe Sharing of Protected Health Information and 42 CFR Part 2: 0 trained vs. 3.5 projected	expected to provide additional training opportunities by December 31, 2018 to meet goal
In progress	B5. Use of IDN HIT Platforms to support information sharing and care coordination: 0 trained vs. 3.5 projected	expected to provide additional training opportunities by December 31, 2018 to meet goal
In progress	B3. CCSA and universal screening: 1 trained vs. 3.5 projected	expected to provide additional training opportunities by December 31, 2018 to meet goal
In progress	B4. Cultural competency and adaptation: 2 trained vs. 3.5 projected	expected to provide additional training opportunities by December 31, 2018 to meet goal
In progress	B5. Care planning and care coordination: 0 trained vs. 3.5 projected	expected to provide additional training opportunities by December 31, 2018 to meet goal
In progress	B6. Co-occurring disorders: 0 trained vs. 3.5 projected	expected to provide additional training opportunities by December 31, 2018 to meet goal
In progress	B8. Understanding addiction: 1 trained vs. 3.5 projected	expected to provide additional training opportunities by December 31, 2018 to meet goal
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.

**attachment\_C1a:**  
**CTI Timeline, Key Milestones and Evaluation Project Targets**

<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
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 Hunter College 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 Hunter College 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 Hunter College.	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 Hunter College 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 MAeHC 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.

Project Team Member and Training/Support	Training/Support Target Date	Training/TA Provider	Role	Credentials	06/30/17 Progress	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
<b>I. Increase core competencies of CTI team to meet program fidelity</b>								
A. CTI team members engage in training provided by Hunter College 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								
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 expected in 2018	Progress not met: training held, but no members of the CTI team participated. More training opportunities will be available by the end of 2018.	
B1b. 42 CFR Part 2 and PHI Sensitive Information Sharing training	expected to be provided by the end of December 2018	TBD			N/A	Progress not met: training expected in 2018	N/A	Not Achieved
B2. Team members participate in use of IDN HIT platforms to support information sharing for care coordination	By December 2018							Not Achieved
B2a. MAeHC Manual Data Portal training	January 4 and 8, 2018	MAeHC			N/A	Progress not met: training expected in 2018	Progress not met: training held, but no members of the team participated. More training opportunities will be available by the end of 2018.	
B2b. CMT Event Notification and Shared Care Plan training	expected to be provided by the end of December 2018	CMT			N/A	Progress not met: training expected in 2018	N/A	Not Achieved
B2c. Knc2 Direct Secure Messaging training	expected to be provided by the end of December 2018	Knc2			N/A	Progress not met: training expected in 2018	N/A	Not Achieved
B3. Team members participate in multi-disciplinary core team (MDCT) training in universal screening	By June 30, 2018							
B4. Team members participate in multi-disciplinary core team (MDCT) training in cultural competency and adaptation	By June 30, 2018							
B5. Team members participate in multi-disciplinary core team (MDCT) training in care planning and care coordination	By December 31, 2018							Not Achieved
B5a. CTI Staff training with Hunter College	March 19-20, 2018	Hunter College			N/A	Progress not met: training expected in 2018	Progress met: 1 CTI team member attended the 2-day training.	
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
B6a. Co-occurring Disorders (SUD and Mental Health Conditions)	June 22, 2018	NH Healthy Families			N/A	Progress not met: training expected in 2018	Progress not met: training was held, but no members of the CTI team attended. Additional trainings on this topic are expected throughout the end of 2018 and 2019.	
B6b. Co-occurring Disorders (Medical and Behavioral Health Conditions)	expected to be completed by end of 2018	TBD			N/A	Progress not met: training expected in 2018	N/A	Not Achieved: progress made w/2 attendance at BH Summit Co-Occurring Disorder trainings
Julia T. (.2 FTE)								
Ashley M. (1 FTE)								
Ian O. (1 FTE)								
B6c. Co-occurring Disorders (SUD and Mental Health Conditions)	expected to be completed by end of 2018	TBD			N/A	Progress not met: training expected in 2018	N/A	Not Achieved: progress made w/2 attendance at BH Summit Co-Occurring Disorder trainings
Julia T. (.2 FTE)								
Ashley M. (1 FTE)								
Ian O. (1 FTE)								
<b>C. CTI team members engage in training and educational opportunities to build their core competencies</b>								
C1. Team members participate in Motivational Interviewing training								
By June 30, 2018								
<b>D. CTI team members engage in Community of Practice (CoP) provided by Hunter College in collaboration with 4 other IDN regions implementing CTI strategy.</b>								
Monthly Community of Practice Call	December 20, 2017	Hunter College			N/A	Progress met: all members of the team participated in the call	N/A	
Monthly Community of Practice Call	January 23, 2018	Hunter College			N/A	N/A	Progress met: all members of the team participated in the call	
Monthly Community of Practice Call	February 28, 2018	Hunter College			N/A	N/A	Progress met: all members of the team participated in the call	
Monthly Community of Practice in-person meeting (Common Man, Plymouth)	March 21, 2018	Hunter College/NH Hospital			N/A	N/A	Progress met: all members of the team participated in this in-person meeting	
Monthly Community of Practice Call	April 25, 2018	Hunter College			N/A	N/A	Progress met: all members of the team participated in the call	
Monthly Community of Practice Call	May 2018	Hunter College			N/A	N/A	Progress met: all members of the team participated in the call	
Monthly Community of Practice in-person meeting (NAMI, Concord)	June 2018	Hunter College			N/A	N/A	Progress met: all members of the team participated in this in-person meeting	
Community of Practice Call	July 2018				N/A	N/A	N/A	Achieved: all members of the team participated in the call
Julia T. (.2 FTE)			CTI Team Coordinator	MBA/LCMHC				
Ashley M. (1 FTE)			CTI Case Manager	BSW				
Ian O. (1 FTE)			CTI Case Manager	BA				
Community of Practice Call	August 2018				N/A	N/A	N/A	Achieved: all members of the team participated in the call
Julia T. (.2 FTE)			CTI Team Coordinator	MBA/LCMHC				
Ashley M. (1 FTE)			CTI Case Manager	BSW				
Ian O. (1 FTE)			CTI Case Manager	BA				
Community of Practice In-Person Meeting	September 2018				N/A	N/A	N/A	Achieved: all members of the team participated in this in-person meeting
Julia T. (.2 FTE)			CTI Team Coordinator	MBA/LCMHC				
Ashley M. (1 FTE)			CTI Case Manager	BSW				
Ian O. (1 FTE)			CTI Case Manager	BA				
Community of Practice Call	October 2018				N/A	N/A	N/A	Achieved: all members of the team participated in the call
Julia T. (.2 FTE)			CTI Team Coordinator	MBA/LCMHC				
Ashley M. (1 FTE)			CTI Case Manager	BSW				
Ian O. (1 FTE)			CTI Case Manager	BA				
Community of Practice Call	November 2018				N/A	N/A	N/A	Achieved: all members of the team participated in the call
Julia T. (.2 FTE)			CTI Team Coordinator	MBA/LCMHC				
Ashley M. (1 FTE)			CTI Case Manager	BSW				
Ian O. (1 FTE)			CTI Case Manager	BA				
Community of Practice In-Person Meeting	December 2018				N/A	N/A	N/A	Achieved: all members of the team participated in this in-person meeting
Julia T. (.2 FTE)			CTI Team Coordinator	MBA/LCMHC				
Ashley M. (1 FTE)			CTI Case Manager	BSW				
Ian O. (1 FTE)			CTI Case Manager	BA				
<b>Increase sustainability of CTI Model</b>								
A. CTI team sends a minimum of 1 member to the CTI Train-the-Trainer training								
A1. Train-the-Trainer training held	August 23-24, 2018				N/A	N/A	N/A	Achieved all members of the team participated in this training

## ***Project 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, Timelines, Core Components, Process Milestones, and Evaluation Project Plan*

The D3 strategies seek to engage a variety of partners to expand SUD treatment options. This includes:

- ~~Student Assistance Program (Project IMPACT) in the Nashua Middle Schools:~~
  - ~~screening/assessments and supportive counseling (The Youth Council)~~
  - ~~as well as referrals to higher levels of treatment, if applicable (The Youth Council, primary care physicians, GNMHC)~~
- ~~Community based non-treatment groups:~~
  - ~~spirituality non-treatment groups (The Emmaus Institute) with screening and referrals/connections to higher levels of treatment~~
- ~~Public health activities to support substance use prevention in greater Nashua:~~
  - ~~Community Health Worker (Community Resource Corps) through Dartmouth Hitchcock Americorps VISTA grant (City of Nashua Department of Public Health)~~
- ~~Emergency Department SUD recovery/transitional care coordination:~~
  - ~~SUD Recovery Care Coordinator (SNHMC)~~
- Expanded SUD treatment for youth/adolescents
  - screening and referrals from Project IMPACT in Nashua Middle Schools (The Youth Council) 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)
  - pre-treatment groups with screening and referrals/connections to higher levels of treatment (Greater Nashua Mental Health in partnership with HEARTS Peer Support and Respite Center)
- Screening and care transitions from hospital emergency departments:
  - assessment and referral to outpatient treatment and other supportive services (Southern NH Medical Center and St. Joseph Hospital)
- Expanded community-based care coordination for SUD referrals to treatment:
  - Support for referrals to treatment and follow-up after treatment (Harbor Homes and Keystone Hall)

#### **Workforce Recruitment/Hiring and Training**

##### ***Progress***

With the learning from the Project IMPACT Student Assistance Program in the Nashua Middle Schools in the pilot year (2017 – 2018) about the gaps in treatment providers for youth screening positive for substance use combined with one of the counselors leaving the program who was currently funded with D3 project funds, **The Youth Council** proposed replacing the Behavioral Health Clinician role with an MLADC/LICSW (1 FTE) and per diem therapists within their organization for their SFY '19 IDN approved funding allocation. These roles support receiving referrals from the Middle School Project IMPACT counselors based upon positive screens and conducting additional assessments, including implementing the Youth CCSA, and if deemed appropriate, providing individual therapeutic services. This expanded service also supports care coordination with IDN primary care providers, including referrals for well-care visits.

**The Emmaus Institute** leveraged their newly trained Pastoral Care Specialists (trained in partnership with the Northeast American Association of Pastoral Care (AAPC) 2017 – 2018) to engage with one of their Licensed Pastoral Psychotherapists (.03 FTEs) to conduct weekly community-based spirituality groups at Revive Recovery Center beginning in June 2018. The goal of these groups is to provide the participants (minimum of 6 and maximum of 12) with a safe place where they can explore their understanding of spirituality in ways it enhances their sense of self and provides meaning for them, including ways that spiritual practices or beliefs have not been helpful or even been detrimental to their recovery. For those seeking additional support or resources, the group facilitators are prepared to make referrals to IDN providers.

With the loss of funding from the Foundation for Healthy Communities *Bridges to Treatment* program, the IDN is funding an SUD Transitional Care Coordinator (.5 FTE Care Coordinator) within **Southern NH Medical Center's** Emergency Department. This individual is also working toward becoming an MLADC.

With respect to training, staff funded as part of D3 project funds participated in the following training opportunities during the reporting period:

#### CCSA/Universal Screening

- The Emmaus Institute (2 LPPs)
- The Youth Council (1 MLADC)

#### Cultural Competence and Adaptation

- Stigma Across Cultures (November 2018)
  - The Emmaus Institute (1 LPP)
  - The Youth Council (2 BH Clinicians and 1 MLADC)

#### Care Planning/Care Coordination

- NH Behavioral Health Summit, through IDN sponsorships (December 2018)
  - The Emmaus Institute (1 LPP)
  - The Youth Council (2 BH Clinicians and 1 MLADC)

#### Other

- Motivational Interviewing
  - Southern NH Medical Center (1 Care Coordinator)

### ***Barriers and Mitigation Plans to Future Achievement***

Lack of progress in achievement of on-boarding for workforce associated with the D3 strategies is due to several issues, for which the IDN is supporting mitigation plans for achievement by the end of the next reporting period. This includes:

- Pre-treatment community-based groups (.03 FTEs Licensed Therapist and .03 FTEs Peer Support Specialist):
  - Issue: these groups did not move forward during the reporting period due to lack of progress in securing the location to house them.
    - Mitigation: GNMH is working closely with local soup kitchens and other community-based locations with the goal of implementation in early 2019 at which point sub-contracting will occur with HEARTS.
- Screening and care transitions from hospital emergency departments:
  - Issue: St. Joseph Hospital and Physician Practices merged with Covenant Health in early 2018, which included a migration of their EHR to Epic. This caused delays in moving forward with implementation of SUD Transitional Care Coordinator in their Emergency Department (.5 FTEs Care Coordinator).
    - Mitigation: the IDN will continue to work with leadership at St. Joseph in early 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 due to concerns about the DSRIP funding uncertainties associated with county contributions as well as legal implications with data sharing causing delays in on-boarding the two Nurses (detox and non-detox) to support for referrals to treatment and follow-up after treatment.
    - Mitigation: the IDN will continue to work with leadership at the two organizations to address the concerns expressed, with the goal of executing the sub-contract in early 2019.

~~During this reporting period, The Youth Council's Project IMPACT Master's Level Student Assistance Counselors continued to operate in the designated middle schools. One Dartmouth Hitchcock CHW assigned to the City of Nashua was on board until the end of October. The SNHMC SUD Recovery Care Coordinator position was maintained and upgraded to 1FTE in the IDN3 FY19 budget. Half of the funding is redeemed from the 2017 approved budget and the other half is in IDN3 supplemental budget request pending approval.~~

~~A number of trainings that were planned for FY19 like the ASAM training, HIPPA and Secure Data Storage and Patient privacy and Consent in relation to 42 CFR Part 2 were not held partly due to scheduling and partly due to a lack of resources/trainers. More training is expected to be provided later in 2019 to achieve the training plan including the planned training for ED Case Managers in ED assessments and proper referral to services.~~

## **Evaluation and Strategy Impacts**

### ***Progress***

Through the beginning of the school year and this reporting period, the two A1-funded Project IMPACT counselors (2 FTEs Behavioral Health Clinicians) completed screenings with 10 youth in the Nashua Middle Schools, with 4 screening positive for depression and 3 screening positive for SUD. Two of those screening positive were referred to the D3-funded licensed therapist (1 FTE MLADC), with an additional 6 youth engaging in expanded individual SUD treatment through IDN funding. During the reporting period, the therapist completed 2 CCSAs, with all youth are encouraged to engage their patients in providing consent.

~~The sub-contracts with The Emmaus Institute were executed during the reporting period.~~ The Emmaus Institute Licensed Pastoral Psychotherapist (.03 FTEs Licensed Therapist) co-facilitated weekly spirituality groups with a trained Pastoral Care Specialist at Revive Recovery Center beginning in June 2018. They ran two community spirituality groups at Revive Recovery Center and the United Methodist Church in Nashua with a total of 18 participants. A number of attendees were repeat participants with one or two new attendees at each session. A related element of this effort is with several of the other Pastoral Care Specialists is funded through the A1 project and involves working with NAMI NH to build a faith/congregation education model in Nashua, Milford, Amherst and Hudson.

The SUD Transitional Care Coordinator (.5 FTEs Care Coordinator) with Southern NH Medical Center (SNHMC) implemented assessments with 127 patients visiting the ED, with 12 of those referred to detox, 10 referred for medication assisted treatment (MAT), 34 referred to community-based SUD recovery centers (including partial hospitalization programs), and 6 back to the Safe Stations team.

#### **Assessment, Treatment, Management and Referral Protocols and Workflows**

##### ***Progress***

As outlined in tables D-6 and D-7, the Youth Council's therapist (1 FTE MLADC) has piloted much of its protocols/workflows related to screening/assessment, treatment, management and referrals. Expanded SUD individual treatment 8 office visits with licensed therapists at the Youth Council office. The Youth Council completed 2 CCSA screenings during the reporting period. There were 4 positive depression screening results and 3 positive substance use risks among children seen. All 7 children had follow up plans developed on the day of screening. The Youth Council replaced the S2BI (SBIRT) tool with CRAFFT effective November 22<sup>nd</sup>, 2018. They were also successful in achieving parental consent and getting signed Releases of Information, allowing them to not only inform the youth and their parents/guardians of the role of the counselors (providing screening/assessments and supportive counseling), but also to educate them about the opportunity to have another resource within the school to link them to needed services (medical and behavioral health) and supports, as well as out-of-school activities.

The SNHMC SUD Recovery Care Coordinator (RCC) strengthened the relationships with IDN member entities, including Safe Stations, Mobile Crisis and peer support agencies. The RCC continued to work with REVIVE and attending monthly Safe Station meetings as well as meet with the Mayor's HIV/AIDS, SUD and OUDs task forces. The RCC will also be meeting with Carol Furlong, 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). It is expected that the Solution Health team would further collaborate with the RCC at Elliot Hospital and The SUD/ODU Recovery Manager, Kim Haney from

Granite Pathways, to discuss community resources as well as how Granite Pathways is integrating with Safe Station.

SNHMC also made progress in the use of HIT vendor platforms, including the installation of shared care plan (through CMT) and event notification and embedded care guidelines for the emergency department (through CMT's PreManage ED). It is expected that better transitional/recovery care coordination will be made for patients interacting with this role and the IDN's community-based services to prevent avoidable ED utilization. Furthermore, the ED Annex has helped to free-up medical beds as patients waiting for inpatient psychiatric admission and ACCESS evaluation are now being housed in the annex.

**Barriers and Mitigation Plans to Future Achievement**

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress not Met: These trainings are currently scheduled for start 2nd Quarter of 2018, engaging all of the D3 positions in their participation.	Progress met: 3 staff funded through D3 participated in educational opportunities/trainings.	Achieved: Achieved in prior reporting period (6/30/18) and additional CCSA training this reporting period
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.	Progress Met: IDN members participated in the 42 CFR Part 2 boot camps provided by the UNH Law School in June and July 2017.	Progress not met: while trainings were held during the reporting period, additional trainings are expected Fall 2018.	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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress Met: IDN members participated in educational sessions hosted by CMT October 2017 on ENS and SCP.	In progress: training was provided by MAeHC in January 2018, with 3 of the 9 staff funded in D3 participating. Additional training from MAeHC is expected in the Fall 2018. Training provided by CMT on ENS and SCP, as well as Kno2 on DSM are expected in Fall 2018.	Achieved: as of yet, no D3 IDN-funded positions attended
Increased knowledge of American Society of Addiction Medicine (ASAM) guidelines to ensure proper placement, continued stay and transfer/discharge 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.	Progress not met: A training was provided for GNMHC staff in January 2018, with training available to other D3 member organizations later in 2018.	In process: 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.	Not Achieved: no ASAM trainings were held
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.	Progress met: Project Impact engaged with primary care providers at Foundation Medical Partners through meetings with 3 of the pediatric practices, as well as at quarterly division meetings of the pediatric and family practices.	Progress met: The Youth Council's Project IMPACT engaged with Harbor Homes, Lamprey Health, and Main Street Pediatrics and Adolescent Medicine.	Achieved: - achieved in prior reporting periods 12/31/17 & 6/30/18 - additional meetings in this reporting period did not take place

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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	Progress met: Project IMPACT engaged with primary care providers at Foundation Medical Partners through meetings with 3 of the pediatric practices, as well as at quarterly division meetings of the pediatric and family practices.	Progress met: Project IMPACT engaged with Harbor Homes, Lamprey Health, and Main Street Pediatrics and Adolescent Medicine.	Achieved: 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
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).	Progress met: 10 youth were screened/assessed by the Project IMPACT counselor(s) in the Nashua Middle Schools. Of those 3 are awaiting further assessment/treatment with higher levels of support from IDN member providers.	Progress met: 58 middle school youth were referred to Project IMPACT counselor(s), with 13 of those screened with the SBIRT tool, identifying only one of 13 had used substances. However eight of 13 (61.5%) screened positive for signs of depression, with seven of those reportedly receiving services for those concerns.	Achieved: 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.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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.	Progress not met: team is working through indicators and processes for tracking progress for this target.	In progress: protocols and tracking mechanisms are still being determined by the team, in collaboration with the IDN Clinical Governance Committee, expected to be finalized by September 2018.	Achieved: <ul style="list-style-type: none"> <li>- 10 children/youth referred to BH services provided by licensed therapist as follows:</li> <li>- 2 referred by school counselors had no shows</li> <li>- 8 referrals received from the drug court/community outreach</li> </ul>
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).	Progress not met: team is working through indicators and processes for tracking progress for this target.	Progress met: 7 middle school youth were referred to primary care physicians through consent and referral protocols implemented by the team.	Achieved: <ul style="list-style-type: none"> <li>- achieved in prior reporting periods 12/31/17 &amp; 6/30/18 with 7 referrals</li> <li>- no additional referrals this reporting period</li> </ul>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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).	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 IDN, with the expectation of making decisions in early 2018.	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.	Achieved: <ul style="list-style-type: none"> <li>- 62 patents referred to appropriate SUD services upon discharge from the ED as follows: <ul style="list-style-type: none"> <li>- 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.</li> </ul> </li> </ul>
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).	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.	In progress: Pre-Treatment Groups: GNMHC but has not finalized the sub-contracting with H.E.A.R.T.S. for co-facilitation role, so groups are expected to begin 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.	Achieved: <ul style="list-style-type: none"> <li>- 18 individuals attended the community spirituality non-treatment groups</li> <li>- 14 Bio-psychosocial assessments completed by Emmaus Institute with licensed pastoral psychotherapist (4 completed CCSAs screenings reported)</li> <li>- GNMHC/HEARTS non-treatment groups to be held in the future</li> </ul>

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
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)	Progress not met: with the migration of a new EHR for St. Joseph Hospital, sub-contracting is not expected until early-mid 2018. SNHMC is in the process of developing its Scope of Work as the funding from Foundation for Health Communities for the current position is ending.	In progress: SNHMC SUD Recovery Care Coordinator served 87 patients, with 73 being referred for additional services. 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.	Achieved <ul style="list-style-type: none"> <li>- 127 patients seen in the ED at SNHMC &amp; assessed with the Patient and Family Services Recovery Care Assessment tool.</li> <li>- 62 patients referred to appropriate SUD services upon discharge from the ED as follows: <ul style="list-style-type: none"> <li>- 12 patients referred for detox services from the ED</li> <li>- 10 Patients referred to MAT services from the ED.</li> <li>- 34 Patients referred to outpatients services with SUD recovery homes/partial hospitalizations upon discharge from ED.</li> <li>- 6 Patients were referred back to Safe Stations upon discharge from the ED.</li> </ul> </li> </ul>

### **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
Mental Health Counselor (Master's Level LMHC)	2	85	86	86	86
Case Manager (RN, Bachelor's Level)	1.2	70.6	70.6	70.6	70.6
Master's Level Team Leader for CTI and IDDT (LCSW or LMHC)	2	98	100	99.2	99
Master's Level Substance Use Disorder Therapist	2	16	17	17	18

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
Mental Health Counselor (MLADC)	1	0	0	0	1
Bachelor's Level Case Manager for Co-located Pilot for Lamprey/GNMHC	1	56	58	59	57
Licensed Pastoral Psychotherapist	.5	2	2	2.5	2.5
Peer Support Specialist	.5	30	30	30	30
SUD Recovery/Transitional Care Case Manager	1	.5	.5	1	1
Community Health Worker	9	40	40	44	44

### 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
Registered Nurse	1.2	0	0	0	0
Licensed Therapist	.06	0	0	.03	.03
Master Licensed Alcohol and Drug Use Counselor (MLADC)	2	0	0	0	1
Behavioral Health Clinician/Specialist	1	0	1	0	0
Care Coordinator	1	0	0	0	.5
Peer Support Specialist	.03	0	0	0	0

### D-4. IDN Community Project: Budget

#### 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): \$80,257.87

- CY 17 (July 2017 – December 2017): \$0

- CY 18 (January 2018 – December 2018): \$80,257.87

\*does not reflect all invoices expected from all IDN Member Entities for the July – December 2018 time frame.

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.

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. 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.

Therefore, expenditures reflected in the budget table below reflect the following:

Employee salary/wages to support:

- Licensed Pastoral Psychotherapist: .25 FTEs
- Mental Health Counselor (MLADC): .15 FTEs
- SUD Transitional Care Coordinator: .5 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

Staff education and training:

- Ethics and communication for Mental Health Counselor

Indirect costs:

- capped at 15% per IDN 3 Finance Committee

## D-4a: IDN Community Project Budget Table

Line Item	Approved Proposed Budget 2016 - 2021	CY 2016 Actuals	CY 2017 Actuals	Jan-June 2018 Actuals	July-Dec 2018 Projected	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	\$784,919.43	\$0.00	\$0.00	\$40,121.00	\$124,254.11	\$31,953.64	\$285,137.92	\$285,137.92	\$142,568.96	\$784,919.44
Employee Benefits	\$938.00	\$0.00	\$0.00	\$938.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$938.00
Consultants	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Equipment (sum of lines below)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Rental		\$0.00	\$0.00	\$0.00						\$0.00
Repair and Maintenance		\$0.00	\$0.00	\$0.00						\$0.00
Purchase/Depreciation		\$0.00	\$0.00	\$0.00						\$0.00
Supplies (sum of lines below)	\$3,933.00	\$0.00	\$0.00	\$3,933.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$3,933.00
Educational		\$0.00	\$0.00	\$0.00						\$0.00
Medical/Lab/Pharmacy		\$0.00	\$0.00	\$0.00						\$0.00
Office	\$3,933.00	\$0.00	\$0.00	\$3,933.00						\$3,933.00
Travel (mileage/parking expenses)	\$491.23	\$0.00	\$0.00	\$270.00	\$0.00	\$221.23	\$0.00	\$0.00	\$0.00	\$491.23
Occupancy	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Current Expenses (sum of lines below)	\$800.00	\$0.00	\$0.00	\$800.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$800.00
Telephone	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Internet costs	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Postage	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Printing and Copying	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Audit and Legal	\$800.00	\$0.00	\$0.00	\$800.00						\$800.00
Insurance	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Board Expenses	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Software	\$280.00	\$0.00	\$0.00	\$0.00	\$0.00	\$280.00	\$0.00	\$0.00	\$0.00	\$280.00
Marketing/Communications	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Staff Education and Training	\$225.00	\$0.00	\$0.00	\$0.00	\$0.00	\$225.00	\$0.00	\$0.00	\$0.00	\$225.00
Subcontracts/Agreements	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other (specific details mandatory):	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Recruitment Fees		\$0.00	\$0.00	\$0.00						\$0.00
Sign-on Bonus		\$0.00	\$0.00	\$0.00						\$0.00
Staff Referral Bonuses		\$0.00	\$0.00	\$0.00						\$0.00
Relocation Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Student Loan Repayment/Reimbursement		\$0.00	\$0.00	\$0.00						\$0.00
Employee Recognition/Retention Bonus		\$0.00	\$0.00	\$0.00						\$0.00
CMEs/Professional Development		\$0.00	\$0.00	\$0.00						\$0.00
Professional Development Fees/Dues		\$0.00	\$0.00	\$0.00						\$0.00
Staff Licensing/Certification Supervision Stipend		\$0.00	\$0.00	\$0.00						\$0.00
Other: please specify below	\$1,516.00	\$0.00	\$0.00	\$1,516.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,516.00
<b>TOTAL</b>	<b>\$793,102.66</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$47,578.00</b>	<b>\$124,254.11</b>	<b>\$32,679.87</b>	<b>\$285,137.92</b>	<b>\$285,137.92</b>	<b>\$142,568.96</b>	<b>\$793,102.67</b>

## 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	<b>CCSA</b> – Use of the Comprehensive Core Standard Assessment process (conducted at a <u>minimum annually</u> ) 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	<b>CCSA</b> – Use of the Youth Comprehensive Core Standard Assessment process (conducted at a <u>minimum annually</u> ) 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.
Project IMPACT Questionnaire	Tool is comprised of 20 questions reflecting the different domains that make up protective factors for at-risk youth including individual, peer, school, family and community.
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. They also complete the Project IMPACT Questionnaire with the student to gather information about protective factors as the basis of an action plan.  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
Adult Medical Detox Assessment	Primary care or other front-line clinicians/providers completing the Comprehensive Standardized Assessment (CCSA) annually will include screening for substance use disorders (via SBIRT). If SUD screen is positive, referrals will be made for a more formal assessment (role/location and tool to be identified/developed) to determine level of care needed. If inpatient detox is indicated, a Nurse Case Manager at Harbor Homes will conduct a more thorough assessment of the patient upon intake. For ED, CCSA completion is not required, but evidence-based screening tool(s) are.	Under Development: expected to be completed in next reporting period
Treatment	The expanded Nurse Case Manager model will deliver an Office-Based Opioid Treatment (OBOT) program at Keystone Hall adding to the program that has existed at Harbor Homes for the last two years. The current treatment protocols in use will be the starting point for this strategy.	Under Development: expected to be completed in next reporting period

Protocol Name	Brief Description	Use (Current/Under Development)
Management	The expanded Nurse Case Manager model will deliver an Office-Based Opioid Treatment (OBOT) program at Keystone Hall adding to the program that has existed at Harbor Homes for the last two years. The current management protocols in use will be the starting point for this strategy.	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).	Under Development: expected to be completed in next reporting period
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 All 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
Master's Level Clinician through Greater Nashua Mental Health Center (GNMHC)	Will provide lead facilitation for pre-treatment groups geared for those experiencing homelessness, to be conducted in homeless shelters and other locations in the community, such as the Rescue Mission or Soup Kitchen using motivational interviewing techniques. Motivational interviewing (ASAM Level 1) will be utilized as a foundation for the groups, with some care management/coordination to referrals for other levels of care as needed/requested by group members for up to 52 groups per year with 2 – 10 participants each.
Certified Peer Recovery Coach or Peer Specialist through H.E.A.R.T.S. Peer Support Center	Will provide co-facilitation role for pre-treatment groups geared for those experiencing homelessness, to be conducted in homeless shelters and other locations in the community, such as the Rescue Mission or Soup Kitchen using motivational interviewing techniques. Motivational interviewing (ASAM Level 1) will be utilized as a foundation for the groups, with some care management/coordination to referrals for other levels of care as needed/requested by group members for up to 52 groups per year with 2 – 10 participants each.

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.
SUD/Recovery Care Coordinator through St. Joseph Hospital	Screens Emergency Department patients for substance use disorder and then refers to appropriate treatment
Nurse Case Managers (Detox and Non-Detox) Harbor Homes/Keystone Hall	Supports adult patients who are struggling with substance use disorders (SUDs) within a Partial Hospital Program (PHP), Residential Detoxification Program and/or Intensive Outpatient Program (IOP) providing evaluation, stabilization (medical and non-medical), and fostering of clients’ entry into higher level 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				

### ***D3 IDN Community Project: Attachments***

attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines, Core Components, Process Milestones, and Evaluation Project Plan

attachment\_D.9a: IDN Community Project Training Plan

**attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines,  
Core Components, Process Milestones and Evaluation Project 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 Plan timeline	
Complete	II. Develop Project Budget	
Complete	A. Develop budget based on selected project strategies	
Complete	B. Review with Clinical Committee who makes recommendation to Finance Committee	
Complete	C. Present to Finance Committee for approval and recommendation to Executive Committee	
Complete	D. Present to Executive Committee for approval	
Complete	E. Budget approved	
Complete	III. Develop Workforce Plan	
Complete	A. Develop Staffing Plan (includes all partner strategies)	
Complete	B. Develop Recruitment Strategies with Project Partners	
Complete	IV. Identify Project Annual Client Engagement Volumes	
Complete	A. Solicit input from IDN project partners	
Complete	B. Develop projections	
Complete	V. Identify Key organizational/provider participants	
Complete	A. Key participants identified	
Complete	B. Letters of Agreements signed	
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	A1. Youth SUD Services in Schools	Shift from S2BI tool to CRAFFT screening in schools effective November 22nd, 2018.
Complete	A1a. The Youth Council	Introduced IDN3 Youth CCSA Paper Version administered by Licensed Therapist through scheduled office visits at the Youth Council. The first CCSA was completed on December 14, 2018.
Complete	A2. Adult Medical Detox	
Complete	A2a. Harbor Homes	The provider has not signed FY19 contract with IDN3. The DSRIP demonstration is not operational
Complete	A2b. Keystone Hall	The provider has not signed FY19 contract with IDN3 contract.
Complete	A3. Adult Community-Based Non-Treatment Groups	
Complete	A3a. GNMHC and HEARTS	Subcontract not executed. Project not operational
Complete	A3b. The Emmaus Institute	administering a biopsychosocial assessment tool by licensed pastoral psychotherapists (LPPs). Started using IDN3 Adult CCSA paper version, December 12, 2018 (date when the first CCSA was completed).
Complete	A4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	A4a. SNMHC	Utilize SNMHC Patient and Family Services Recovery Care Assessment tool.
Complete	A4b. St. Joseph Hospital and Physician Practices	The provider has not signed FY19 contract with IDN3 contract.
Complete	B. Work with project strategy partners to identify potential assessments to be used	
Complete	B1. Youth SUD Services in Schools (CRAFFT)	Shift from S2BI tool to CRAFFT screening tool in schools effective November 22nd, 2018 and followed by PHQ-9 for depression screening.
Complete	B1a. The Youth Council (CCSA)	Introduction of IDN3 Youth CCSA Paper Version effective 12/14/2018. Prior used GAIN-SS (short screener) and S2B1 for cases referred to the Youth Council.
Complete	B2. Adult Medical Detox	
Complete	B2a. Harbor Homes	The provider has not signed FY19 contract with IDN3. The DSRIP demonstration is not operational
Complete	B2b. Keystone Hall	The provider has not signed FY19 contract with IDN3. The DSRIP demonstration is not operational
Complete	B3. Adult Community-Based Non-Treatment Groups	
Complete	B3a. GNMHC and HEARTS	Providers have not signed the subcontract to co-facilitate this activity.
Complete	B3b. The Emmaus Institute	No assessments conducted at community spirituality groups.
Complete	B4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	B4a. SNMHC	The Patient and Family Services Recovery Care Assessment tool is used for assessments.
Complete	B4b. St. Joseph Hospital and Physician Practices	The provider has not signed a contract with IDN3.
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	Activity was completed. Gap analysis on protocols to take place as part of December 2018 SSA survey and quality improvement planning.
Complete	A1a. The Youth Council	Activity was completed. Gap analysis on protocols to take place as part of December 2018 SSA survey and quality improvement planning.
Complete	A2. Adult Medical Detox	
Complete	A2a. Harbor Homes	The provider has not signed FY19 contract with IDN3. DSRIP demonstration is not operational
Complete	A2b. Keystone Hall	The provider has not signed FY19 contract with IDN3. DSRIP demonstration is not operational
Complete	A3. Adult Community-Based Non-Treatment Groups	
Complete	A3a. GNMHC and HEARTS	Providers have not signed FY19 subcontract to co-facilitate non-treatment groups. DSRIP demonstration is not operational

**attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines,  
Core Components, Process Milestones and Evaluation Project Plan**

Status	Task Name	Comments
Complete	A3b. The Emmaus Institute	List of protocols for licensed pastoral therapist consultations and counseling was completed and includes: 1). Biopsychosocial screening tool. LPP are responsible for screening; 2) Summary Notice of privacy practices; 3). Agreement to Treat; 4). Whole life counseling and psychotherapy: Issues and personal profile; 5) Consent to use or disclose information for treatment, payment, and healthcare operations; 6). Counseling Services: Information for Patient Billing; 7) Personal Inventory Form/Intake; 8): Quick Inventory of Depressive Symptomatology ( Self-Report) QIDS-SR.; 9). Medication Checklist. Gaps identified: Referral form; Recovery monitoring and tracking protocol; Patient referral resource sheet as gaps to be addressed as part of Jan-June 2019 improvement milestones.
Complete	A4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Incomplete	A4a. SNMHC	Protocols are in place for assessment, referral, discharge, ED team meetings and patient referral to specialist or outpatient services. The provider is using Patient and Family Services Recovery Care Assessment tool. To verify with RCC if the Recovery Care Assessment tool is evidenced-based.
Incomplete	A4b. St. Joseph Hospital and Physician Practices	The provider has not signed a B1 and D3 contract with IDN3.
Complete	B. Work with project strategy partners to identify potential protocols and workflows to be used	
Complete	B1. Youth SUD Services in Schools	The provider has replaced S2BI tool with a CRAFFT screening tool in schools effective November 22nd, 2018. CRAFFT screening workflows in place.
Incomplete	B1a. The Youth Council	Using IDN3 Youth CCSA protocols and referral pathways. The provider plans to develop protocols for (i) follow up for positive screening results; (ii) recovery monitoring and tracking of ED utilizers and other high risks children and adolescents etc.
Complete	B2. Adult Medical Detox	
Complete	B2a. Harbor Homes	The provider has not signed FY19 B1 and D3 contracts with IDN3. The DSRIP demonstration is not operational
Complete	B2b. Keystone Hall	The provider has not signed FY19 B1 and D3 contracts with IDN3. The DSRIP demonstration is not operational
Complete	B3. Adult Community-Based Non-Treatment Groups	
Incomplete	B3a. GNMHC and HEARTS	Providers have not signed FY19 subcontract to run non-treatment groups. The DSRIP demonstration is not operational
Incomplete	B3b. The Emmaus Institute	LPPs completes CCSAs. Follow up and referral protocols for positive screening outcomes not in place. Revision of workflows will be done in 3rd or 4th quarter of FY19 if the project coordinator position is approved and funded.
Complete	B4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	B4a. SNMHC	Provider has protocols in place for assessment, referral, discharge, ED team meetings and patient referral to specialist or outpatient services. The provider is using Patient and Family Services Recovery Care Assessment tool.
Incomplete	B4b. St. Joseph Hospital and Physician Practices	The provider has not signed a contract with IDN3.
Complete	III. Identify/Develop Roles and Responsibilities of Team Members	
Complete	A. Work with program strategy leads to establish roles and responsibilities of team members	
Complete	A1. Youth SUD Services in Schools	Established roles for counselors in school. Supervised for LISWC credential.
Complete	A1a. The Youth Council	Roles and workflows for licensed therapists are being revised in line with D3 contract. Final workflows to be shared with IDN3 clinical governance committee.
Complete	A2. Adult Medical Detox	
Complete	A2a. Harbor Homes	The provider has not signed a D3 and B1 contract with IDN3
Complete	A2b. Keystone Hall	Providers have not signed a D3 contract with IDN3
Complete	A3. Adult Community-Based Non-Treatment Groups	
Complete	A3a. GNMHC and HEARTS	Providers have not signed the subcontract for this activity.
Complete	A3b. The Emmaus Institute	One Licensed Pastoral Therapist and 3 Pastoral Care Specialist trained in spirituality in patient care, mental health awareness and SUD prevention education and responsible in co-facilitating community spirituality groups.
Complete	A4. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	A4a. SNMHC	Provider has protocols in place for assessment, referral, discharge, ED team meetings and patient referral to specialist or outpatient services. The provider is using Patient and Family Services Recovery Care Assessment tool.
Complete	A4b. St. Joseph Hospital and Physician Practices	The provider has not signed a B1 and D3 contract with IDN3.
Complete	IV. Identify/Develop Training Plan	
Complete	A. Assess staff training needs of each project strategy	
Complete	A1. Solicit training needs from each project strategy partner	N/A
Complete	A2. Work with each project strategy partner and IDN 3 work teams to identify training needs for staff	N/A
Complete	B. Create logistics plan for trainings	
Complete	C. Contract with vendors/purchase trainings	
Complete	D. Schedule trainings	
Complete	E. Identify mechanisms for participants to engage in trainings	
Complete	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	

**attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines,  
Core Components, Process Milestones and Evaluation Project Plan**

<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
In progress	A. Work with IDN Member Entity leadership to execute sub-contracts	
Complete	A1. Youth SUD Services in Schools	Completed/executed FY19 A1and A2 contract, October 8th, 2018
Complete	A1a. The Youth Council	complete/executed FY18 D3 contract, November 22, 2018
Not started	A2. Adult Medical Detox	
Not started	A2a. Harbor Homes	The provider has not signed FY19 contract with the IDN3. The DSRIP demonstration is not operational
Not started	A2b. Keystone Hall	The provider has not signed FY19 contract with the IDN3. The DSRIP demonstration is not operational
In progress	A3. Adult Community-Based Non-Treatment Groups	
Incomplete	A3a. GNMHC and HEARTS	Providers have not signed FY19 subcontract to co-facilitate non-treatment groups. DSRIP demonstration is not operational
In progress	A3b. The Emmaus Institute	Two spirituality community groups are operational. The first group meets at REVIVE Recovery Center and the second group at Main Street Methodist Church/Agape. A total of 18 individuals have attending the group meetings. Most are duplicates/regular attendees with few new members joining from time to time. The model is however experiencing low attendance patterns, with some weeks of zero attendance.
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. IDN3 funding is 0.5FTE during the reporting period.
In progress	A4b. St. Joseph Hospital and Physician Practices	The provider has not signed a B1 and D3 contract with IDN3.
In progress	VII. Develop evaluation plan, including metrics that will be used to measure program impact	
Complete	A. Middle School Student Assistance Program (Project IMPACT) evaluation targets identified	
Complete	A1. Project IMPACT evaluation targets identified	
Complete	B. Adult Medical Detox evaluation targets identified	
Complete	B1. Adult medical detox evaluation targets are identified	The provider has not signed a D3 and B1contract with IDN3
Complete	B2. Adult medical non-detox evaluation targets are identified	Providers have not signed a D3 contract with IDN3
In progress	C. Adult Community-Based Pre-Treatment and Non-Treatment Groups targets identified	
Complete	C1. Spirituality community-based non-treatment group evaluation targets identified	System for tracking attendance, new participants and referrals not developed.
Complete	C2. Pre-treatment community-based group evaluation targets identified	Providers have not signed FY19 subcontract to co-facilitate non-treatment groups. DSRIP demonstration is not operational
Complete	D. SUD/recovery transitional care coordination from Hospital Emergency Departments targets identified	
Complete	C1. SNMHC SUD/recovery care transition evaluation targets identified	Completed
Complete	C2. St. Joseph Hospital SUD/recovery care transition evaluation targets identified	The provider has not signed a contract with IDN3.
Incomplete	VIII. Identify mechanisms (registries) to track and monitor individuals served by the program, adherence, and impact measures.	Incomplete.
Complete	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	
Incomplete	A1. GNMHC, SNMHC, Harbor Homes, Keystone Hall, and St. Joseph Hospital and Physician Practices will utilize EHR to monitor and track patients and impacts	St. Joseph Hospital and Physician Practices completes the EPIC system installation and staff capacity building. The Provider signed the A2 contract with the IDN3 on 12/08/2018. Keystone and Harbor Home does not have a signed contract with IDN3 during the reporting period.
incomplete	A2. The Emmaus Institute will utilize spreadsheets to track and monitor patients and impacts	Patient tracking system (registry/spreadsheets) not developed for providers without electronic health record system
Complete	B. Use of HIT platforms to track and monitor individuals served by strategies	
Complete	B1. Identify organizations who will utilize CMT platform for ENS and SCP	The provider has signed a A2 contract. The provider has been connected with CMT (Alex). A discovery form will be sent to Emmaus Institute to complete for CMT registration.
In progress	B2. Identify organizations who will utilize Kno2 platform for DSM	The contract with DSM and KNO2 is pending.
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 IDN 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)	
Complete	A1a. Master's Level staffing on-boarded	2 x Master level counselors Jamie Faulhaber and Erin Richardson retained and now in the second year of employment on the Student IMPACT project. The two staff are beneficiaries of the student loan repayment plan. 2 x MSW interns were hired from Revier University and joined the Youth Council on September 26, 2018. One intern resigns after completing orientation.
Not started	A2. Adult Medical Detox	
Not started	A2a. Detox RN Case Manager on-boarded	The provider has not signed a D3 or B1 contract with IDN3.
Not started	A2b. Non-Detox RN Case Manager on-boarded	The provider has not signed a D3 or B1 contract with IDN3.
Complete	A3. Spirituality Community-based Non-Treatment Groups	
Complete	A3a. Licensed Pastoral Psychotherapist on-boarded	2x licensed pastoral psychotherapist on board. The IDN3 funding 0.75 FTE for LPP and 0.5 FTE for Admin Assistant
Complete	A4. Pre-Treatment Community-based Groups	
Complete	A4a. Master's Level clinician on-boarded	Use of existing GNMHC clinical staff to execute this new strategy. However, the activity is not operational because a subcontract between GNMHC and HEARTS has not been signed.
Complete	A4b. Peer Support Specialist on-boarded	Use of existing H.E.A.R.T.S. staff to execute this new strategy. However, the activity is not operational because a subcontract between GNMHC and HEARTS has not been signed.

**attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines,  
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<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
Complete	A5. SUD/recovery transitional care coordination from Hospital Emergency Departments	
Complete	A5a. SNHMC SUD Recovery Care Coordinator on-boarded	complete. The Recovery Care Coordinator (RCC) position is 0.5FTE during this reporting period. A supplemental budget was submitted to IDN3 that includes another 0.5FTE for this position.
Not started	A5b. Peer Support Specialist on-boarded	The position is not budgeted in FY19. The Recovery Care Coordinator makes referrals to REVIVE peer support agency. 5 patients were referred to REVIVE peer support services during the reporting period.
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. HIPPA 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. there was no training on privacy during the reporting period.
In progress	A1b. Patient Privacy and Consent re: 42 CFR Part 2	The training was not offered during the reporting period.
In progress	A2. CCSA and Universal Screening	
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. 4 staff from the Youth Council attended the CCSA implementation readiness training on 11/15/2018 and the MAeHC platform training on 11/29/2018. Out of the 4 staff, one is an intern (MSW) and two are licensed therapist; and 1 is Program Director. The licensed therapist are per diem employees and the intern are funded by the IDN3.
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 IDN protocols/guidelines	The Youth Council completed 2 x IDN3 Youth CCSA paper versions with the first screening complete don 12/14/2018. The Emmaus Institute completes 4 x IDN3 CCSA paper version (adults) with the first screening completed on 12/12/2018.
In progress	A3. Use of HIT platforms (ENS, DSM, SCP) to support information sharing and communication workflows and protocols	
In progress	A3a. Use of MAeHC 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 MAeHC tool by December 31, 2018. Orientations on MAeHC portal was done with Emmaus Institute staff on 11/28/2018 and with the Youth Council on 11/29/2018.
In progress	A3b. Use of CMT for Event Notification (ENS) and Shared Care Plan (SCP)	expected to be provided by December 31, 2018
In progress	A3c. Use of Kno2 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. This training was not offered during the reporting period.
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. Follow up training with the new IDDT team (5staff) and Emmaus Institute (1 xLPP) was held by Case Western in October, 2018. IXRCC (SNHHC) attended a NADAAC SUD and opioids preventing education, White River Junction.
In progress	A4c. Co-Occurring Disorders (Medical and Behavioral Health Disorders)	This training was no offered during the reporting period.
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	
Complete	A5a. Unpacking Assumptions provided by Ascentria Care Alliance	3 members of the D3 IDN-funded workforce participated in this training in March 2018. This was training was offered to Douglas Wentworth staff ( Non-IDN3 entity) in November 2018.
Complete	A5b. Stigma Across Cultures provided by Ascentria Care Alliance	1 members of the D3 IDN-funded workforce participated in this training in May 2018. 2 Emmaule Institute staff ( 1xLPP and 1 x Direct Support Staff) attended Stigma across cultures at GNMHC on 11/02/2018.
In progress	III. Implementation of any required updates to clinical protocols, or other operating policies and procedures	
Complete	A. Student Assistance Program (Project IMPACT)	
Complete	A1. Pilot screening/assessment and referral protocols	Complete, with protocols, policies and procedures identified by The Youth Council having been piloted. Based on lessons learned, a decision was made to shift from S2BI to CRAFFT tool on November 22, 2018. The IDN3 Youth CCSA paper version was introduced on 12/14/2018 ( date of the first completed CCSA at the Youth Council).
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	The provider has not signed a D3 contract with IDN3.
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	Providers have not signed a subcontract to co-facilitate this activity.
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	Community spirituality became operational from June 26, 2018. The first group was held at REVIVE Recovery Center, a peer support agency and the second group was started at the Main Street Methodist Church/Agape.
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. The IDN3 funds 0.5FTE of the Recovery Care Coordinator position during this reporting period. A supplemental budget proposal was submitted to the IDN3 to upgrade this position to 1FTE and is pending approval by the Finance Committee.
In progress	F. SUD Recovery/Transitional Care Case Manager Intervention (St. Joseph Hospital)	

**attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines,  
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<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
In progress	F1. Expectation to begin supporting patients in the ED by end of first quarter of 2018, upon execution of sub-contract	The position is not filled. The Provider has not signed a D3 or B1 contract with IDN3.
In progress	IV. Use of assessment, treatment, management and referral protocols	
Complete	A. Student Assistance Program (Project IMPACT)	
Complete	A1. Meet with IDN Admin Lead and Clinical Committee review screening/assessment, management, and referral protocols	The Youth Council was a key player in reviewing the IDN3 Youth CCSA paper version.
Complete	A2. Finalize screening/assessment, management, and referral protocols	The CCSA policies and guidelines was approved by the Clinical Governance on July12. Following subsequent corrections and comments received from DHHS on IDN3 CCSA tool, the revised tool was resubmitted to clinical governance committee for approval. The tool was approved November 2018.
Complete	A3. Pilot screening/assessment, management, and referral protocols	Complete, with protocols piloted during the school calendar.
Not started	B. Adult Medical Detox (Detox and Non-Detox)	
Not started	B1. Meet with key clinical and HIT leaders and decision-makers to outline screening/assessment, treatment/management and referral protocols	The provider has not signed a D3 contract with IDN3.
Not started	B2. Finalize protocols and workflows	The provider has not signed a D3 contract with IDN3.
Not started	B3. Expectation to begin enrolling patients by mid-2018, upon execution of sub-contract	The provider has not signed a D3 contract with IDN3.
In progress	C. Adult Community-Based Pre-Treatment Groups	
Complete	C1. Meet with facilitators to determine any screening and referral protocols to be implemented	N/A
In progress	C2. Begin outreach to secure potential participants	Providers have not signed a subcontract to co-facilitate this activity.
In progress	C3. Expectation to begin enrolling group members by end of first quarter of 2018, upon execution of sub-contract	Providers have not signed a subcontract to co-facilitate this activity.
In progress	D. Adult Community-Based Spirituality Non-Treatment Groups	
Complete	D1. Meet with facilitators to determine any screening and referral protocols to be implemented	N/A
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). A marketing brochure to promote spirituality is included on smart sheet.
Complete	D3. Expectation to begin enrolling group members by end of first quarter of 2018, upon execution of sub-contract	Groups begun meeting on June 26, 2018. The first event was held at REVIVE Recovery Center.
In progress	E. SUD Recovery/Transitional Care Case Manager Intervention (SNHMC)	
Complete	E1. Meet with key clinical leaders and HIT staff	Pre-Manage/Community ED installation.
Complete	E2. Finalize HIT platform implementation and clinical workflows with clinical leaders and decision-makers	SNHHS has executed contract with Kno2 for DSM and with CMT for PreManage ED/
Complete	E3. Expectation to begin supporting patients in the ED by end of first quarter of 2018, upon execution of sub-contract	Operational. A total of 127 patient screened through the ED during the reporting period.
In progress	F. SUD Recovery/Transitional Care Case Manager Intervention (St. Joseph Hospital)	
Complete	F1. Meet with key clinical leaders and decision-makers	The provider has not signed a D3 contract with IDN3.
Incomplete	F2. Work through HIT platform implementation and clinical workflows with clinical leaders and decision-makers	The provider has not signed a D3 contract with IDN3.
Incomplete	F3. Expectation to begin supporting patients in the ED by end of second quarter of 2018, upon execution of sub-contract	The provider has not signed a D3 or B1 contract with IDN3.
In progress	<b>Stage 2: Project Utilization Milestones (Initiation of Data Reporting) July to December 2017</b>	
In progress	I. Reporting on number of individuals served (during reporting period and cumulative), vs. projected	
Complete	A1. Student Assistance Program (Project IMPACT)	
Complete	A1a. 10 youth referred and enrolled vs. 30 projected	10 Youth were seen. 4 positive screen for depression and 3 positive screen for substance use risk; and 2 completed CCSA screenings; 7 children had follow up plan developed on the day of positive screening results.
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	The provider has not signed a D3 contract with IDN3.
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	Providers have not signed a subcontract for this activity.
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 begun on 26 June 2018 at Revive Recovery Center and United Methodist Church (Nashua)
Complete	A5. SUD Recovery/Transitional Care Case Manager Intervention (SNHMC)	
Complete	A5a. Expectation to begin supporting patients in the ED by end of first quarter of 2018, upon execution of sub-contract	127 patients seen through the ED. All 127 individuals were assessed with the Patient and Family Services Recovery Care Assessment tool. 62 patents 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.
In progress	A6. SUD Recovery/Transitional Care Case Manager Intervention (St. Joseph Hospital)	
In progress	A6a. Expectation to begin supporting patients in the ED by end of first quarter of 2018, upon execution of sub-contract	The provider has not signed a D3 contract with IDN3. The CHW assigned to the unit by Dartmouth Hitchcock/AmeriCorps Vista program resigned by the end of April 2018.
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	2 x interns (MSW) were hired from Rivier University. One intern, Matt Betts is still on board. The second intern resigned at the end of the orientation week, October 6th, 2018.

**attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines,  
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<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
Not started	A2. Adult Medical Detox: 0 staff recruited/on-boarded vs. 2 (1.2 FTEs) projected	The provider has not signed a D3 contract with IDN3.
Complete	A3. Community-based Non-Treatment Groups: 2 facilitators recruited vs. 3 projected	Providers have not signed a subcontract for this activity.
Complete	A4. Hospital Emergency Department SUD Transitional Care: 1 recruited/on-boarded (.5 FTEs) vs. 2 projected (.5 FTEs)	SNHMC coordinator is on-board. The CHW from the Dartmouth Hitchcock/AmeriCorps program was placed at City of Nashua Public Health Department. She was on board between March to October 30, 2018. The St. Joseph Hospital coordinator position not filled. The CHW at St. Joseph Hospital and Physician Practices was on board between March-April 2018. The provider has not signed a B1 or D3 contract with IDN3
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. HIPPA 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. This training was not offered during the reporting period.
In progress	A1b. Patient Privacy and Consent re: 42 CFR Part 2	This training was not offered during the reporting period.
In progress	A2. CCSA and Universal Screening	Training expected in early 2018
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. 9 Staff completed CCSA implementation readiness training. Includes 5 from the Youth Council and 4 from Emmaus Institute. Out of 9, there are 5 IDN funded positions.
In progress	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 IDN protocols/guidelines	7 members of the clinical governance committee attended the CCSA process orientation on Dec 14, 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 MAeHC 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 MAeHC tool by December 31, 2018.
In progress	A3b. Use of CMT for Event Notification (ENS) and Shared Care Plan (SCP)	29 Participants attended the CMT shared care plan/ENS webinar on October 23 and 26th, 2019.
In progress	A3c. Use of Kno2 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. 6 participants attended the co-occurring disorder training at GNMHC with the IDDT team (October 2018). One participant, Rev Manseau was from the Emmaus Institute. The rest were IDDT participants.
In progress	A4c. Co-Occurring Disorders (Medical and Behavioral Health Disorders)	This training was not offered during the reporting period.
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. 1 training offered at Douglas Wentworth Hospital ( November 2018)- not an IDN3 member;
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. Four participants attended this training at GNMHC on 11/02/2018. A second training held at Easter Seal, Manchester ( Non -IDN member).
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 IDN-funded positions in the D3 strategies participate in universal screening training by 12/31/18.	<b>Progress Not Met:</b> 5 X staff from the Youth Council (2 per diem therapist and 1 intern funded by IDN3) attended the CCSA implementation readiness training; 4 STAFF from Emmaus Institute ( 2 licensed pastoral psychotherapist (0.75FTE) and 2 Admin assistants (0.5 FTE each) attended the training.
Complete (du	B. Up to 9 IDN-funded positions in the D3 strategies participate in universal screening training by 12/31/18.	<b>Progress Not Met:</b> IDN3 did not provide this training during the reporting period.
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: IDN members participated in educational sessions hosted by Collective Medical Technologies on October 23rd and 26th to provide an overview of the event notification and shared care plan platforms.
Incomplete	D. Up to 4 of the IDN-funded positions in the D3 strategies participate in the ASAM training by 12/31/18.	<b>Progress Not Met:</b> This training was not offered
Incomplete	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 SBIRT and referral resources by 12/31/18.	<b>Progress Not Met:</b> There was no outreach events held with PCPs or BH providers during the reporting period. Outreach events were with community-based organizations and includes: Grow Nashua and four meetings with Community Families Committee.
Incomplete	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)	<b>Progress Not Met:</b> 10 youth were screened/assessed through The Youth Council's Project IMPACT, the Student Assistance Program being piloted in the Nashua Middle Schools. of those screened/assessed, 3 were positive for substance user risks; and 4 positives for depression. There were 2 completed CCSA screenings during the reporting period.
Incomplete	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	<b>Progress Not Met:</b> There were no presentations made on Project IMPACT activities to primary care providers or to other behavioral health providers during the reporting period.
Not started	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)	<b>Progress Not Met:</b> The provider has not signed a D3 contract with IDN3.
Incomplete	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)	<b>Progress Not Met:</b> Two community spirituality groups operational. 18 attendees (largely repeat attendees/duplicate). Attendance fluctuates from 0-12 participants. The GNMHC-HEARTS subcontract for the community pre-treatment group has not been signed. The project is not operational.

**attachment\_D.1a: IDN Community Project: Implementation Plan, Timelines,  
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Status	Task Name	Comments
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)	<b>Progress Met:</b> 127 patients seen in the ED at SNHMC. All 127 individuals were assessed with the Patient and Family Services Recovery Care Assessment tool. 62 patents 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.
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	A. Student Assistance Program in Nashua Middle Schools: 58 youth served vs. 60 projected	<b>Progress Not Met:</b> 6 middle school youth were seen by counselors and screened using CRAFFT tool. 10 were seen by licensed therapist in planned office visits.
Complete	B. Adult Medical Detox: 0 served vs. 125 projected	<b>Progress Not Met:</b> The provider has not signed a D3 contract with IDN3.
Complete	C. Community-based non-treatment groups: 0 individuals served vs. 80 projected	<b>In process:</b> Pre-Treatment Groups: 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	<b>Progress Met:</b> SNHMC SUD Recovery Care Coordinator served 127 patients, with 62 being referred for additional services.
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	<b>Progress Met:</b> 2 Master level counselors assigned to Middle Schools: Erin Richardson and Jamie Faulhaber are still on board. One intern, Matt Betts is on board for 3 months. The second intern resigned after completing orientation.
Not started	A2. Adult Medical Detox: 0 staff recruited/on-boarded vs. 2 (1.2 FTEs) projected	The provider has not signed a D3 contract with IDN3.
Complete	A3. Community-based Non-Treatment Groups: 2 facilitators recruited vs. 3 projected	<b>Progress Not Met:</b> GNMHC has not executed the sub-contract with H.E.A.R.T.S. for co-facilitation of community-pre-treatment groups.
Complete	A4. Hospital Emergency Department SUD Transitional Care: 1 recruited/on-boarded (.5 FTEs) vs. 2 projected (.5 FTEs)	<b>Progress Not Met:</b> SNHMC coordinator on-boarded. The IDN3 funds 0.5FTE of the position. The second 0.5FTE is in supplemental budget request for FY19, pending approval by the Finance Committee. St. Joseph Hospital coordinator position is not filled. The Provider has not signed a D3 or B1 contract with IDN3.
Complete	B. Number of staff trained (during reporting period and cumulative) vs. projected	
Complete	B1. Patient Privacy/Consent and Secure Data Storage	
Complete	B1a. HIPPA 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	
Complete	B2c. Use of CCSA process with overview of IDN protocols/guidelines: 0 trained vs. 9 projected	
Complete	B3. Use of HIT platforms (ENS, DSM, SCP) to support information sharing and communication workflows and protocols	
Complete	B3a. Use of MAeHC Data Portal and Patient Dashboard for IDN Data Reporting: 3 trained vs. 9 projected	
Complete	B3b. Use of CMT for Event Notification (ENS) and Shared Care Plan (SCP): 0 trained vs. 9 projected	expected to be conducted by December 31, 2018
Complete	B3c. Use of Kno2 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	
Complete	A. 3 vacant positions (1.7 FTEs) vs. 0 projected	
Complete	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 IDN-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 oppoort/trainings.
Complete	B. Up to 9 IDN-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 MAeHC in January 2018, with 3 of the 9 staff funded in D3 participating. Additional training from MAeHC is expected in the Fall 2018. Training provided by CMT on ENS and SCP, as well as Kno2 on DSM are expected in Fall 2018.

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<b>Status</b>	<b>Task Name</b>	<b>Comments</b>
Complete	D. Up to 4 of the IDN-funded positions in the D3 strategies participate in the ASAM training by 12/31/18.	In progress: 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 SBIRT 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 SBIRT 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 IMPACT 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).	
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.	<b>Progress Not Met:</b> 10 Referrals from community/drug court system to the Youth Council. No referrals made from the Youth Council to PCP for well-care visits, or to other BH Providers or community-based organizations
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.	<b>Progress Not Met:</b> There were no outreach events with PCPs or other BH providers during the reporting period. Outreach with community based organizations including Grow Nashua and Community Family Committee was held to educate the CBOs on IMPACT pilot project. There were no referrals made to the CBOs during the reporting period.
Complete	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)	<b>Progress not met:</b> The Partnership for Successful Living has had significant turnover in leadership and is evaluating timing and ability to implement strategies within the IDN, 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)	<b>Progress not met:</b> 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)	<b>Progress not met:</b> St. Joseph Hospital and Physician Practices have not signed a contract with IDN3.

**attachment\_D1.9  
Training Plan**

Project Team Member	12/31/17 Progress	06/30/18 Progress	7/1/18-12/31/18 Progress
Student Assistance Counselor (The Youth Council)			
HIPPA and Secure Data Storage	In Progress: This training will 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.	<b>Progress Not Met:</b> This training was not offered during the reporting period. The Provider began contacts with SAGE data security to develop a NIST assessment contract and their HIT vendor - "IT Insiders" to do a NIST assessment.
Universal Screening/Assessment Tools	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 will be provided additional trainings specific to the CCSA and universal screening by December 31, 2018.	<b>Progress Met:</b> 5 staff from the Youth Council attended the CCSA implementation readiness training on 11/15/2018. 2 x staff are funded through a D3 per diem obligation and includes the licensed therapists (Lindsay Bergeron and Patty Zarembo) and 1 x graduate (MSW) intern (Matt Betts). 4 x Staff including Christina Connor (Programs Director) and Donna Arias (Executive Director) attended the MAeHC platform orientation on 11/29/2018.
Patient Privacy and Consent related to 42 CFR Part 2	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.	<b>Progress Not Met:</b> The IDN did not provide this training during the reporting period.
Communication Protocols and Workflows (through HIT vendor technologies)	Progress Met: The Youth Council participated in the IT/Data and Clinical Governance Committee educational sessions provided by both MAeHC (September 2017) and CMT (October 2017).	Progress not met: this role did not participate in the training provided by MAeHC (May 2018). Trainings for the use of CMT (event notification and shared care plan) and Kno2 (direct secure messaging) will be held in late 2018.	<b>Progress Met:</b> 5 staff from the Youth Council attended the MAeHC platform orientation training on 11/29/2018. 2x staff are per diem and one is an MSW intern from Rivier University.
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	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.	<b>Progress Not Met:</b> This training was not offered during the reporting period. However 1 staff ( Christina Connor) attended MHFA training October 2018.
Recovery/Transitional Care Coordinator (St. Joseph Hospital)			
HIPPA and Secure Data Storage	N/A: This position not yet been on-boarded, as the IDN sub-contract has not been executed due to delays in the migration of their EHR. 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 role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Met:</b> The A2 contract has been signed with the provider on 12/08/2018. The provider has received two orientations on MAeHC platform to support data entry and reporting. Internal EPIC system installation completed.
Universal Screening/Assessment Tools	N/A: This position not yet been on-boarded, as the IDN sub-contract has not been executed due to delays in the migration of their EHR. 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 has not been on-boarded yet, but is expected by October 2018.	<b>Progress Met:</b> Training on policies and guidelines associated with IDN3 CCSA tool has been conducted through 1:1 meetings with providers and through conference calls with Jackie Balardo, MAeHC Data Consultant.
Patient Privacy and Consent related to 42 CFR Part 2	N/A: This position not yet been on-boarded, as the IDN sub-contract has not been executed due to delays in the migration of their EHR. This training will be provided to IDN treatment providers in mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period.
Communication Protocols and Workflows (through HIT vendor technologies)	N/A: This position not yet been on-boarded, as the IDN sub-contract has not been executed due to delays in the migration of their EHR. Training/educational opportunities will be provided for use of CMT and Kno2, as well as other HIT platforms by mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Met:</b> The provider has executed A2 contract on 12/08/2018. The provider has attended at least 2 orientations with MAeHC on aligning DSRIP performance measures and reporting with their EPIC electronic health record system. CMT platform training on SCP and ENS was held on 10/23 and 10/26/2018. However, key data reporting staff from the Provider did not attend.
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	N/A: This position not yet been on-boarded, as the IDN sub-contract has not been executed due to delays in the migration of their EHR. This training will be provided to IDN treatment providers in mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period.
Recovery/Transitional Care Coordinator (Southern NH Medical Center)			
HIPPA and Secure Data Storage	N/A: This position not yet been on-boarded as an IDN-funded position (it is currently being piloted under an outside grant). It is expected a sub-contract with the IDN to fund this position/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 will 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.	<b>Progress Met:</b> The provider has completed installation of PreManage ED, ENS system in the hospital electronic health record system. ED staff capacity building to effectively use the system is ongoing. The RCC is expected to train the 3 ed Case Managers on screening and documentation and reporting of admissions, discharges and referrals in the system.
Universal Screening/Assessment Tools	N/A: This position not yet been on-boarded as an IDN-funded position (it is currently being piloted under an outside grant). It is expected a sub-contract with the IDN to fund this position/strategy will be executed by early-mid 2018. This training will 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 will be provided additional trainings specific to the CCSA and universal screening by December 31, 2018.	<b>Progress Met:</b> The provider has not attended training on SBIRT or other evidence-based screening protocols. The Provider is using Patient and Family Services Recovery care Assessment tool. 127 assessments were conducted using this tool. The RCC plans to train ED Case Managers on screening and assessment protocols during the 3rd quarter of FY19.
Patient Privacy and Consent related to 42 CFR Part 2	N/A: This position not yet been on-boarded as an IDN-funded position (it is currently being piloted under an outside grant). It is expected a sub-contract with the IDN to fund this position/strategy will be executed by early-mid 2018. Training/educational opportunities will be provided for use of CMT and Kno2, 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.	<b>Progress Not Met:</b> This training was not provided during the reporting period. However, the RCC attended NADAAC training at White River Junction that address privacy in relation to SUD and opioids treatment. The RCC also attended Harm reduction training in Springfield, Vermont in relation.
Communication Protocols and Workflows (through HIT vendor technologies)	N/A: This position not yet been on-boarded as an IDN-funded position (it is currently being piloted under an outside grant). It is expected a sub-contract with the IDN to fund this position/strategy will be executed by early-mid 2018. Training/educational opportunities will be provided for use of CMT and Kno2, as well as other HIT platforms by mid-2018.	Progress not met: this role did not participate in the training provided by MAeHC (May 2018). Trainings for the use of CMT (event notification and shared care plan) and Kno2 (direct secure messaging) will be held in late 2018.	<b>Progress Met:</b> The provider has completed installation of PreManage ED, ENS system in its electronic record system. ED staff capacity building to effectively use the system is ongoing. The RCC is expected to train the 3 ED Case Managers on screening and assessments; documentation and reporting of admissions, discharges and referrals.
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	N/A: This position not yet been on-boarded as an IDN-funded position (it is currently being piloted under an outside grant). It is expected a sub-contract with the IDN to fund this position/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.	<b>Progress Not Met:</b> This training was not provided during the reporting period.
Detox Nurse (Keystone Hall/Harbor Homes)			
HIPPA and Secure Data Storage	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in 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 will include use of universal screening tools: PHQ-2/9 and SBIRT.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period. The provider has not signed a D3 or B1 contract with IDN3 in FY19.
Universal Screening/Assessment Tools	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in early-mid 2018. This training will be provided to IDN treatment providers in mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> One member ( Melbourne Moran) attended this training through the clinical governance committee and through the full IDN meeting ( September 2018). However the provider has not signed an A1, A2, B1 or D3 contract in FY19.
Patient Privacy and Consent related to 42 CFR Part 2	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in early-mid 2018. This training will be provided to IDN treatment providers in mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period. The provider has not signed a D3 or B1 contract with IDN3 in FY19.
Communication Protocols and Workflows (through HIT vendor technologies)	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in early-mid 2018. Training/educational opportunities will be provided for use of CMT and Kno2, as well as other HIT platforms by mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> CMT platform training on SCP and ENS was held on 10/23 and 10/26/2018. Melbourne Moran attended (To verify??) However, without the FY19 contract being signed, there were no key staff (clinical, data and reporting) participating in this training.
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in 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 role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period. The provider has not signed a D3 or B1 contract with IDN3 in FY19.
Non-Detox Nurse (Harbor Homes/Keystone Hall)			
HIPPA and Secure Data Storage	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in 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 will include use of universal screening tools: PHQ-2/9 and SBIRT.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period. The provider has not signed a D3 or B1 contract with IDN3 in FY19.
Universal Screening/Assessment Tools	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in early-mid 2018. This training will be provided to IDN treatment providers in mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> One member ( Melbourne Moran) attended this training through the clinical governance committee and through the full IDN meeting ( September 2018). However the provider has not signed an A1, A2, B1 or D3 contract in FY19.
Patient Privacy and Consent related to 42 CFR Part 2	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in early-mid 2018. This training will be provided to IDN treatment providers in mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period. The provider has not signed a D3 or B1 contract with IDN3 in FY19.

attachment\_D1.9  
Training Plan

Project Team Member	12/31/17 Progress	06/30/18 Progress	7/1/18-12/31/18 Progress
Communication Protocols and Workflows (through HIT vendor technologies)	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in early-mid 2018. Training/educational opportunities will be provided for use of CMT and Kno2, as well as other HIT platforms by mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> CMT platform training on SCP and ENS was held on 10/23 and 10/26/2018. A total of 29 Providers representative attended the training and included mainly IDN3 clinical staff, quality assurance and data/report writing staff and case managers. Without the FY19 contract being signed, there were no key staff involved in these trainings.
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	N/A: This position not yet been on-boarded, due to leadership changes in the organizations, but sub-contracts are expected to be executed in 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 role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not provided during the reporting period. The provider has not signed a D3 or B1 contract with IDN3 in FY19.
<b>Community-Based Spirituality Group Facilitator</b>			
HIPPA and Secure Data Storage	In Progress: This training will 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.	<b>Progress Not Met:</b> This training was not provided during the reporting period. The provider has not signed a D3 subcontract with HEARTS to facilitate this activity.
Universal Screening/Assessment Tools	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 role participated in both the DH CCSA/Social Determinants of Health learning session (March 2018) and the Engaging Partners in Addressing Social Determinants of Health Training provided by DHHS/Myers and Stauffer (May 2018).	<b>Progress Met:</b> 2 Licensed pastoral therapist are funded by the IDN3 and constitute 0.75 FTE and the other two are direct support staff/admin associate who constitute 0.5 FTE of IDN3 funding.
Patient Privacy and Consent related to 42 CFR Part 2	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.	<b>Progress Not Met:</b> This training was not offered during the reporting period. However, 2 x staff (1 clinical staff- Rev. Dr. William Manseau) and 1 direct support staff ( Holly Pettit) from Emmaus Institute attended IDN3 funded Stigma across Cultures 11/02/2018. Bill also attended a non-IDN3 Post traumatic healing training at the Roxbury PresbyterianChurch Social Impact Center;
Communication Protocols and Workflows (through HIT vendor technologies)	Progress Met: The Licensed Pastoral Psychotherapists participated in the IT/Data and Clinical Governance Committee educational sessions provided by both MAeHC (September 2017) and CMT (October 2017).	Progress met: this role participated in the MAeHC Data Portal training in January 2018. Trainings for the use of CMT (event notification and shared care plan) and Kno2 (direct secure messaging) will be held in late 2018.	<b>Progress Met:</b> CMT platform training on SCP and ENS was held on 10/23 and 10/26/2018. A total of 3 staff including 2 licensed pastoral psychotherapists and 1 direct support staff attended the training. Two staff attended the MAeHC orientation training on 11/28/2017 and included 1x licensed pastoral psychotherapist (Rev. Dr. David Sundell) and 1direct support staff (Holly Pettit)
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	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).	<b>Progress Not Met:</b> This training was not offered during the reporting period. However 1 Licensed Pastoral Psychotherapist (Rev. Dr. William Manseau) attended a co-occurring disorder training with the IDDTteam in October 2018 at GNMHC
<b>Community-Based Pre-Treatment Group Facilitator</b>			
HIPPA and Secure Data Storage	In Progress: This training will be provided by the IDN 2 separate days/times via webinar: March 19 and 30, 2018	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not offered during the reporting period.
Universal Screening/Assessment Tools	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 has not been on-boarded yet, but is expected by October 2018.	<b>Progress Met:</b> 2x GNMHC leadership staff attended the CCSA training. The provider is expected to implement their own CCSA tool during the reporting period.
Patient Privacy and Consent related to 42 CFR Part 2	Progress Not Met: This training will be provided to IDN treatment providers in mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not offered during the reporting period.
Communication Protocols and Workflows (through HIT vendor technologies)	Progress Not Met: Training/educational opportunities will be provided for use of CMT and Kno2, as well as other HIT platforms by mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress met:</b> 2xHIT staff attended several trainings on Patient link platform. 3x staff have attended orientation on MAeHC portal for data reporting.
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	Progress Not Met: This training is being planned for mid-2018.	Progress not met: this role has not been on-boarded yet, but is expected by October 2018.	<b>Progress Not Met:</b> This training was not offered during the reporting period.
<b>Community-Based Pre-Treatment Group Co-Facilitator</b>			
HIPPA and Secure Data Storage	In Progress: This training will 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 (March 2018).	<b>Progress Not Met:</b> This training was not offered during the reporting period.
Universal Screening/Assessment Tools	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 will be provided additional trainings specific to the CCSA and universal screening by December 31, 2018.	<b>Progress Met:</b> 1xHEARTS staff (Ken Lewis) attended the training at the full IDN meeting of September 2018. The provider is not expected to implement the CCSA but receive general education to effectively support peer services and education of patients on the importance of universal screening in coordinated/integrated care services.
Patient Privacy and Consent related to 42 CFR Part 2	Progress Not Met: This training will be provided to IDN treatment providers in mid-2018.	Progress met: This role participated in the 42 CFR Part 2 "boot camp" provided by UNH Law School in June/July 2017.	<b>Progress Not Met:</b> This training was not offered during the reporting period.
Communication Protocols and Workflows (through HIT vendor technologies)	Progress Not Met: Training/educational opportunities will be provided for use of CMT and Kno2, as well as other HIT platforms by mid-2018.	Progress met: this role participated in the MAeHC Data Portal training in January 2018. Trainings for the use of CMT (event notification and shared care plan) and Kno2 (direct secure messaging) will be held in late 2018.	Progress Not Met.
American Society of Addiction Medicine (ASAM) Criteria guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions	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).	<b>Progress Not Met:</b> This training was not offered during the reporting period.

## ***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**

The IDDT team has continued to engage with Case Western Reserve University in consultation, training and fidelity assessment/action planning during this reporting period, reaching the fidelity model caseload of 75 by December 31, 2018. For details on the E4 implementation plan, see attachment\_E.1a.

#### **Implementation of Workforce Plan**

*Staffing: recruitment, retention, and sustainability*

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

- Team Lead/Clinical Leader (1 FTE)
- SUD Therapist (1 FTE)
- Mental Health Therapist (1 FTE)
- Case Managers (2 FTEs)
- Nurse (.5 FTEs)
- Psychiatric APRN (.5 FTEs)
- Peer Support Specialist (.5 FTEs)
- Supported Employment Specialist (.5 FTEs)
- Criminal Justice Specialist/Liaison (.1 FTEs)
- Housing Specialist (.1 FTEs)
- Family Specialist (.1 FTEs)

Throughout the first year of the pilot program, much was learned about the staffing model that would serve this population most effectively. As part of that learning and some of the more recent departures, all members of the team fill the role of outreach/community engagement and case management, including the therapists and psychiatric staff, when applicable and appropriate. Additionally, it was determined that the case managers might be served more effectively as Master's Level Clinical Case Managers, so one of the existing positions was filled at that level. As of the end of the reporting period, the staffing model is as follows:

- Team Lead/Clinical Leader: minimum Master's level, licensed clinician (1 FTE)
- Psychiatrist: MD or psychiatric APRN: (.5 FTE)
- Co-Occurring Disorders Therapist: minimum Master's level, licensed clinician (2 FTEs)
- Case Manager: minimum Bachelor's Level, with Master's level preferred (2 FTEs)
- Nurse: RN (.5 FTEs)
- Peer Support Specialist (.5 FTEs)
- Criminal Justice Specialist/Liaison (.1 FTE)

- Housing Specialist (.1 FTE)
- Family Specialist (.1 FTE)

As of the end of the reporting period, the following provider roles were filled:

- Psychiatrist (.5 FTE)
- Nurse (.5 FTE Registered Nurse)
- Team Lead (1 FTE Licensed Therapist)
- Therapist (2 FTEs Licensed Therapist)
- Case Manager (2 FTEs)
- Criminal Justice Specialist/Liaison (.10 FTEs in-kind)
- Housing Specialist (.10 FTEs in-kind)
- Family Specialist (.10 FTEs in-kind)

#### ***Barriers and Mitigation Plans to Future Achievement***

The Peer Support Specialist (.5 FTEs) role will be filled by HEARTS Peer Support and Respite Center. Sub-contracting was completed between the two organizations at the end of the reporting period, with the goal of on-boarding an individual in early 2019.

Several key IDDT team roles had been become vacant during the reporting period.

- The Supported Employment Specialist (.5 FTEs) left the state, moving to Texas for family-related reasons. This was a critical role for the IDDT team to support the programmatic outcome target of sustained employment.
  - Mitigation: GNMH will utilize its IDN funding allocation to support continued use of sponsored ads on recruitment sites, targeted ads on professional association sites, as well as hiring incentives such as sign-on bonuses, staff referral bonuses, and existing loan repayment opportunities within the organization and state.
- Peer Support Specialist (.5 FTEs) has not been filled through a sub-contract with HEARTS Peer Support and Respite Center as of the end of the reporting period.
  - Mitigation: GNMH is finalizing the sub-contracting process and expects to have this role on board in early 2019.
- The Psychiatric role (.5 FTEs) was filled by a Psychiatric APRN in early 2018, but this individual left the organization to pursue other opportunities.
  - Mitigation: GNMH has temporarily filled this role on the team with one of their Psychiatrists (MD), but is utilizing the IDN relocation funds, recruitment funds (sponsored ads and advertising on professional association sites), as well as sign-on bonuses and retention bonuses to entice qualified applicants.

The IDN is funding a Website Design Consultant to support streamlining GNMH's website and online application process to create a more integrated online application to streamline the process for applicants as well as HR. Additionally, GNMH is utilizing IDN funding to support a Compensation Analyst Consultant to provide an analysis of comparable organizations regarding compensation/incentive packages and provide suggestions for how to attract and retain staff. This will allow the organization to address the perception that their salaries are not competitive as well as allow staff to grow within their agency, rather than view them as a training ground to leave once they have obtained experience.

## Movement Toward Program Fidelity

The team **continues to** work closely with Case Western through their **IDN-funded** consultation and technical assistance. **They completed their** Fidelity Action Plan in early 2018 to address the recommendations outlined in the Baseline Fidelity Assessment **conducted in late 2017**. A one-year fidelity assessment is planned for early 2019 to assess progress.

### *Progress*

Given the staffing turnover mid-**late** 2018, the action plan strategies had a lull in their progress. Now that the team formation includes a Clinical Case Manager and recently on-boarded staff, **they** understand the need for all members to engage in engagement/outreach and case management (regardless of their role), and the **fidelity action plan strategies** are again at the forefront. Successes in achieving the evaluation targets outlined in the E-2 table include:

- Reaching fidelity caseload levels: 75 clients
- Team knowledge/skills in IDDT evidence-based fidelity model:
  - Training:
    - Stage 1 and 2 training completed in September 2018.
      - This training was initially conducted in December 2017 by Case Western Reserve University, but due to staff turnover since that time, the determination was made to conduct it again to ensure all staff participation.
    - Stage 3 and 4 training will be conducted in early-mid 2019 by Case Western Reserve University.
    - Motivational Interviewing (2-day training) was completed by the team in March/April 2018, with Advanced Motivational Interviewing (2-day) provided in June 2018.
    - Knowledge of patient consent/privacy requirements (HIPAA and 42 CFR Part 2)
      - Completed with all team members as part of GNMH on-boarding process with new staff and/or annual compliance training.
    - MDCT trainings provided/funded by the IDN
      - Advanced Motivational Interviewing (July 2018)
      - Unpacking Assumptions (September 2018)
      - Chronic Disease and Behavioral Health (October 2018)
      - NH Behavioral Health Summit
  - Technical assistance (TA) provided by Case Western Reserve University:
    - Weekly one-one-one TA with the IDDT Team Lead to support operationalization of fidelity model and staffing trouble-shooting.
    - Minimum monthly TA with the full IDDT team
- Standardized process/tools for referrals, screening and assessment, treatment and management:
  - Referrals:
    - The IDDT referral form (attached) has been finalized the referral process further refined/improved in the EMR with community partners and internal GNMH SUD and ACT teams being educated on the inclusion or exclusion criteria for IDDT.
  - Screening, assessment and treatment/management:

- Protocols have been developed and workflows are being operationalized with support/guidance provided by Case Western Reserve University.
    - The team participates in training and technical assistance at minimum monthly through Case Western Reserve University. These sessions include fidelity model for care coordination/case management as part of treatment planning.
    - GNMH leadership has conducted training with the team to support the assessment of daily functioning, including the social determinants of health as part of implementation of the CCSA process.
    - Final standardized processes and tools are expected by early 2019 and will be provided to the IDN.
  - Clinical case reviews/management:
    - Internal: The team maintains daily clinical case reviews to identify and address emergent client and administrative issues, working through the client list alphabetically by who on the team met last with them and identifying what stage of treatment they are currently. Weekly case management meetings are also conducted.
    - External: the team has met with staff from InteGreat Health to conduct case management for shared clients.
- Reaching IDDT program fidelity:
  - Now that the Fidelity Action Plan has been developed, bi-weekly fidelity action implementation meetings (every other Tuesday) are conducted, including all IDDT team members, as well as an SUD and compliance representative from GNMH.
  - Beginning in September 2018, fidelity action plan implementation meetings are held twice per month, with support from Case Western and where applicable, the IDN Clinical Governance Committee/IDN Admin Lead.
  - The goal for 2019 is to identify members and begin to operationalize an IDDT Steering/Advisory Committee.

### ***Barriers and Mitigation Plans to Future Achievement***

Achieving the programmatic outcome targets for IDDT set in 2017 has been challenging to report against for the following reasons:

- Identification of indicators and access to data/information sources has been limited.
  - Mitigation: while GNMH has a robust EHR, now that it has contracted with both Kno2 and CMT to support interoperability of shared PHI and receipt of timely emergency department, urgent care, and inpatient admissions, discharges and transfers (ADTs), these additional sources of data and the ability to add care guidelines and care team information will be possible to support tracking and achievement of these outcomes.
- The CCSA process, initially through the use of the ANSA tool and now with the DLA-20 tool, requires staff training and support for operationalization prior to confidence in their use as tracking tools.
  - Mitigation: the team engaged in operationalizing the process for implementation of these new tools/processes during the reporting period. Workflows and protocols are in the final stages of being shared with team members, including the determination of how to engage in shared care plans as part of the CCSA implementation process using the ANSA tool, and in early 2019, using the DLA-20 tool. Working with Case Western Reserve University and IDN Clinical Governance Committee will enable the team to meet the fidelity action goals

and build internal team processes for expanded case management and care coordination in 2019.

### **Training:**

Given the turnover early mid 2018 of many of the initial members of the IDDT team, IDDT team members consulted with Case Western Reserve University and determined they would conduct a second 2-day training session for Stage 1 (Engagement) and Stage 2 (Persuasion) 2-day training in September 2018 to allow those new staff to learn in collaboration with the remaining team members. The second training on the remaining stages of treatment (Stage 3: Action and Stage 4: Relapse Prevention) will occur in early 2019.

Some of the team members also participated in other training geared toward Multi-Disciplinary Teams, including:

- Advanced Motivational Interviewing (July 2018)
- Unpacking Assumptions (September 2018)
- Chronic Disease and Behavioral Health (October 2018)
- NH Behavioral Health Summit

Finally, as part of the IDN's contract with Case Western Reserve University, the IDDT team engaged 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 Infrastructure**

The team maintains daily clinical case reviews to identify and address emergent client and administrative issues, working through the client list alphabetically by who on the team met last with them and identifying what stage of treatment they are currently.

Now that the Fidelity Action Plan has been developed, bi-weekly fidelity action implementation meetings (every other Tuesday) are conducted, including all IDDT team members, as well as:

- An SUD representative from GNMHC
- A compliance representative from GNMHC

Beginning in September 2018, implementation meetings are held twice per month, with support from Case Western and where applicable, the IDN Clinical Governance Committee/IDN Admin Lead. The goal of identifying and developing an IDDT Steering/Advisory Committee is planned for early 2019.

### **Technology Support:**

Currently, the majority of information is input and stored as part of GNMHC's Electronic Health Record (EHR), with the exception of the tracking of referrals through closed loop on an Excel spreadsheet.

Kno2 for Direct Secure Messaging (DSM) is now operational, along with the event notification and shared care plan platform with CMT beginning its operations in early 2019.

Workflows and protocols are in the final stages of being shared with team members, including the determination of how to engage in shared care plans as part of the CCSA implementation process using the ANSA tool, and in early 2019, using the DLA-20 tool.

## E-2. IDN Community Project: Evaluation Project Targets

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	Progress met: 44 individuals are being served by the IDDT program as of June 30, 2018.	Achieved: The maximum caseload per program fidelity has been reached at 75
Number of clients served by the IDDT team	A minimum of 60 individuals served by the program by December 31, 2018	Progress met: 44 individuals are being served by the IDDT program as of June 30, 2018.	Achieved: The maximum caseload per program fidelity has been reached at 75
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.	In progress: an additional training on Stages of Treatment focusing on Engagement (Stage 1) and Persuasion (Stage 2) is scheduled for September 25 and 26, 2018 to train new IDDT team members and provide a refresher training to existing team members.	Achieved: Team participated in Case Western training in September 2018 and have participated in bi-weekly (minimum) technical assistance.
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.	Progress met: 11 members of the IDDT team participated in a 2-day Motivational Interviewing training on either March 26 and April 2, 2018 (provided by Peter Fifield) or June 21 and June 28, 2018 (provided by David Lynde and Christine Powers).	Achieved: Team participated in Case Western training <b>(Stages 1 and 2) in September 2018, in addition to motivational interviewing training (2-day training: March/April 2018 and 2-day advanced training: June 2018).</b> In addition, members of the team have participated in bi-weekly (minimum) technical assistance.

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	In progress: 2 trainings were held (by the IDN in March: HIPAA and Secure Data and by UNH Law School in March: 42 CFR Part 2) with members of GNMHC attending, but not members of the IDDT team. Additional training related to patient consent and sensitive information sharing under 42 CFR Part 2 will be provided by December 31, 2018.	<b>Achieved:</b> <b>All team members engaged in training on patient confidentiality and consent requirements under HIPAA and 42 CFR Part 2 as part of the GNMH hiring/on-boarding process and participate in annual (minimum) training thereafter.</b>
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.	In progress: Monthly technical assistance is being provided by Case Western Reserve University, with additional training scheduled to be provided September 25 and 26, 2018 (for Stages of Treatment One and Two) to train the 4 new IDDT team members and enable a review of the standardized processes and tools to meet program fidelity.	Achieved: Team participated in Case Western training in September 2018 and have participated in bi-weekly (minimum) technical assistance.
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.	Progress met: The IDDT team has developed and is using a referral form to receive internal referrals. The agency is evaluating the use of referral forms and will likely revamp tools and processes across the agency in the next reporting period.	Achieved: The referral form has been <b>completed and the referral process</b> further refined/improved in the EMR with community partners being educated on the inclusion or exclusion criteria for IDDT in conjunction with the SUD and ACT teams. <del>so GNMHC's array of services are being shared with partners.</del>

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	Progress met: Ongoing IDDT clinical team meetings daily to conduct case reviews and address emergent client and administrative issues.	Achieved: <b>Team participates in training and technical assistance at minimum monthly through IDN funded contract with Case Western Reserve University. These sessions include fidelity model for care coordination/case management as part of treatment planning.</b>
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.	In progress: The IDDT team worked with the IDN's Shared Care Plan and Case Management Work Team to identify potential strategies for pulling in partners to think more broadly about the case management related to IDDT given the challenges this particular sub-population has. Weekly case management meetings are held with the IDDT team, as well as technical assistance related to the development of the IDDT Fidelity Action Plan.	Achieved: <b>The IDDT team conducts weekly case management meetings and has met with staff from InteGreat Health to conduct case management for shared clients. GNMH leadership has conducted training with the team to support the assessment of daily functioning, including the social determinants of health as part of implementation of the CCSA process.</b>
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.	In progress: Processes and tools are being piloted internally, with support from Case Western. These protocols and tools are identified in E4-6 and E4-7.	Achieved: <b>The protocols and workflows have been developed and are being operationalized. Final standardized processes and tools are expected by early 2019 and will be provided to the IDN. Completed as part of Fidelity Action Plan.</b>

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	In progress: The team has already begun utilizing the Adult Needs and Skills (ANSA), which will support the domains required for the CCSA and process for using the results as part of the client's care plan. The team is also investigating the potential of training staff and implementing a train-the-trainer model for beginning to utilize the Daily Living Assessment (DLA) - 20. Together, these tools will help the team set the baseline and evaluate progress toward this goal by the end of 2018 and beyond.	Achieved:  GNMH is working with the IDN to operationalize what indicators should be used for "independent living skills." As part of team training and initial use of the DLA-20 in late 2018, it is expected that data will be available to support this measure by early 2019.  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
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.	In progress: The team has already begun utilizing the Adult Needs and Skills (ANSA), which will support the domains required for the CCSA and process for using the results as part of the client's care plan. The team is also investigating the potential of training staff and implementing a train-the-trainer model for beginning to utilize the Daily Living Assessment (DLA) - 20. Together, these tools will help the team set the baseline and evaluate progress toward this goal by the end of 2018 and beyond.	Not Achieved:  <b>Of the approximately 75 clients enrolled in IDDT from July 1 – Dec 31, 14 were employed as of December 31. Vacancy of Supported Employment Specialist at the end of the reporting period impacted the ability to support the entire group of clients, however through use of IDN workforce incentive funding, active interviewing is in progress to fill this critical position, allowing for progress in achievement of this outcome target in 2019.</b>

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	In progress: GNMHC engaged with MAeHC to enable encounter-based data file extracts to be reported to DHHS, as well as enable monitoring and addressing gaps in meeting outcome measure goals/activities. Additionally, they have been working with PatientLink to determine the feasibility of utilizing the platform for delivering the CCSA to patients electronically and/or integrating the results directly into GNMHC's EMR.	Achieved: Contracting and operationalization steps have been completed with Collective Medical Technologies (CMT) to enable the ability to receive emergency department, urgent care, and inpatient admissions, discharges and transfers (ADTs) and <b>operationalize care guidelines/shared care plan through IDDT Case Managers</b> . Contracting and operationalization steps also completed with Kno2 to enable direct secure messaging (DSM).
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.	In progress: The team has already begun utilizing the Adult Needs and Skills (ANSA), which will support the domains required for the CCSA and process for using the results as part of the client's care plan and is also investigating the potential of training staff and implementing a train-the-trainer model for beginning to utilize the Daily Living Assessment (DLA) - 20. Together, these tools will help the team set the baseline and evaluate progress toward this goal by the end of 2018 and beyond.	Not Achieved: <b>GNMHC is operationalizing the definition of "improvement in functioning" through use of DLA-20. Team members were trained in use of the tool and operationalization began in December 2018. It is expected the use of the DLA-20 will allow for data collection on this measure by June 30, 2019.</b>

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	Progress not met: IDDT team is determining the indicators and tracking process for meeting this target.	Not Achieved: GNMHC has baseline data <b>to support this outcome target, but is further determining indicators and tracking process in collaboration with Case Western Reserve University as part of their IDN funded technical assistance and clinical consultation. Expectation is that progress toward this target will be achieved through ongoing use of the CCSA process and engagement in case management activities with other IDN Member Entities.</b> <del>contracted was unable to provide it by the deadline of publication of this report.</del>

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	In progress: The team has already begun utilizing the Adult Needs and Skills (ANSA), which will support the domains required for the CCSA and process for using the results as part of the client's care plan and is also investigating the potential of training staff and implementing a train-the-trainer model for beginning to utilize the Daily Living Assessment (DLA) - 20. Together, these tools will help the team set the baseline and evaluate progress toward this goal by the end of 2018 and beyond.	Not Achieved: GNMHC has baseline data <b>to support this outcome target, but is further determining indicators and tracking process in collaboration with Case Western Reserve University as part of their IDN funded technical assistance and clinical consultation.</b> Expectation is that progress toward this target will be achieved through ongoing use of the CCSA process and engagement in case management activities with other IDN Member Entities. <del>but was unable to provide it by the deadline of publication of this report.</del>
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.	In progress: The team has already begun utilizing the Adult Needs and Skills (ANSA), which will support the domains required for the CCSA and process for using the results as part of the client's care plan and is also investigating the potential of training staff and implementing a train-the-trainer model for beginning to utilize the Daily Living Assessment (DLA) - 20. Together, these tools will help the team set the baseline and evaluate progress toward this goal by the end of 2018 and beyond.	Not Achieved: GNMHC has baseline data <b>to support this outcome target, but is further determining indicators and tracking process in collaboration with Case Western Reserve University as part of their IDN funded technical assistance and clinical consultation.</b> However, The IDDT team connects on a regular basis with the drug and mental health court liaisons. GNMHC is working with the mental health court liaison to assist clients in remaining in the community.

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	Progress not met: The team is awaiting information related to the Experience of Care Survey to be implemented as part of the DSRIP evaluation plan.	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.
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.	In progress: The team has already begun utilizing the Adult Needs and Skills (ANSA), which will support the domains required for the CCSA and process is also investigating the potential of training staff and implementing a train-the-trainer model to utilize the Daily Living Assessment (DLA) - 20. Together, these tools will help the team set the baseline and evaluate progress toward this goal by the end of 2018 and beyond.	Not Achieved: <del>No data available at the time of publication of this report.</del> <b>While GNMH has data to support this outcome target, will gain additional insights from the event notification (ENS) ADTs, allowing for the team to proactively identify strategies to impact this outcome beginning in early 2019. Expectation is that progress toward this target will be achieved through ongoing use of the CCSA process and engagement in case management activities with other IDN Member Entities.</b>
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.	In progress: The team has already begun utilizing the Adult Needs and Skills (ANSA), which will support the domains required for the CCSA and process is also investigating the potential of training staff and implementing a train-the-trainer model to utilize the Daily Living Assessment (DLA) - 20. Together, these tools will help the team set the baseline and evaluate progress toward this goal by the end of 2018 and beyond.	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.

Performance Measure Name	Target	Progress Toward Target	
		As of 6/30/18	As of 12/31/18
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.	In progress: The team has begun recording the stage of treatment in all clinical progress, functional support, case management, and case conference. IT should be able to report out on this across time for any and all clients.	Not Achieved: Stages of change are being tracked and clients are making changes, but GNMH is still working on quantifying this data. <b>Expectation is that progress toward this target will be achieved through ongoing use of the CCSA process and engagement in case management activities with other IDN Member Entities.</b>
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).	Progress not met: The team is awaiting information related to the Experience of Care Survey to be implemented as part of the DSRIP evaluation plan.	Not Achieved: Awaiting implementation of DSRIP Patient Satisfaction Survey through University of Southern Maine.
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: Case Western Reserve University conducted the IDDT Baseline Fidelity Assessment in December 2017, providing 55 recommendations to the IDDT team in February 2018 (see attachment_E4.2a).	In progress: This work continues with Case Western Reserve University, with a one-year fidelity review being completed in early 2019.

### 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
Licensed Therapist	1	98	99	99	99
Master's Level Mental Health Therapist	0	85	85	85	85
Master's Level SUD Counselor	0	16	17	16	16

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
<b>Mental Health Counselor (Psy.D.)</b>	1	0	0	0	1
Mental Health Counselor (Master's Level LCMHC/LICSW)	9	85	85	92	91
Licensed Pastoral Psychotherapist	.75	2	2.75	2.75	2.75
<b>Clinical Case Manager (Master's Level)</b>	1	0	0	1	1
Behavioral Health Case Manager (Bachelor's Level)	2	56	58	58	57
Case Manager (RN Bachelor's Level)	1.2	70.6	70.6	70.6	70.6
Recovery/Transitional Care Case Manager	1	.5	.5	.5	.5
Nurse (Associate's Level)	.5	73	73	73.5	73.5
Psychiatrist/Psychiatric APRN	.5	3	3	3.5	3.5
Peer Support Specialist (sub contract with H.E.A.R.T.S. Peer Support Center)	1	30	30	30	30
Supported Employment Specialist	.5	11	11	11.5	11
Criminal Justice Specialist/Liaison	.1	6	6.1	6.1	6.1
Housing Specialist	.1	3	3.1	3	3.1
Family Specialist	.1	6	6.1	6.1	6.1
Community Health Worker	9	40	40	44	44

### E-3. IDN Community Project: Workforce Staffing

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need to Achieve IDDT Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Psychiatrist	.5	0	0	.5	.5

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need to Achieve IDDT Strategies	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Registered Nurse	.5	0	0	0	.5
Licensed Therapist	3	0	3	3	3
Case Manager	2	0	2	2	2
Criminal Justice Specialist/Liaison	.10	0	0	.10	.10
Supported Employment Specialist	.5	0	0	.5	0
Housing Specialist	.10	0	0	.10	.10
Family Specialist	.10	0	0	.10	.10
Peer Support Specialist	.5	0	0	0	0

#### 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): \$136,991.69

- CY 17 (July 2017 – December 2017): \$0
- CY 18 (January 2018 – December 2018): \$136,991.69
  - Jan – June 2018 actuals: \$81,926.00
  - July – December 2018 actuals: \$55,065.69

~~\*does not reflect all invoices expected from all IDN Member Entities for the July – December 2018 time frame.~~

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).

Projections are displayed for ~~the July to December 2018, as well as~~ CY 2019, CY 2020 and CY 2021 (January to June) in the IDN Community Project Budget Table (E-4a) at the end of this section. Below is more detail to support those budgets.

##### *Approved Funding Allocations/Projections*

Employee salary/wages to support:

- Psychiatrist/Psychiatric APRN (.5 FTEs)
- RN ~~(Associate's Level)~~ (.5 FTEs)
- Licensed Therapist (3 FTEs), including Integrated Dual Diagnosis Treatment (IDDT) Team Coordinator and two dual diagnosis therapists
- ~~Clinical~~ Case Manager ~~(Master's Level 2 FTEs)~~, **one of which being a Clinical Case Manager (Master's Level)**
- Criminal Justice Specialist (.10 FTEs **in-kind**)
- Supported Employment Specialist (.5 FTEs)
- Housing Specialist (.10 FTEs **in-kind**)
- Family Specialist (.10 FTEs **in-kind**)

Consultants:

- Peer Support Specialist (.5 FTEs): **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.~~

~~Therefore,~~ Expenditures reflected in the budget table below reflect the following:

Employee salary/wages to support:

- Psychiatrist (.5 FTEs October - December)
- Integrated Dual Diagnosis Treatment (IDDT) Team Coordinator (Licensed Therapist: 1 FTE)
- Licensed Therapist (2 FTEs)
- RN (.5 FTEs)
- Case Manager (2 FTEs)
- Supported Employment Specialist (.5 FTEs through mid-December)

Supplies to support:

- office and educational
  - IDDT educational brochure
- Laptops
- Client needs

Travel to support:

- mileage

Current expenses to support:

- mobile phones

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	Jan-June 2018 Actuals	July-Dec 2018 Projected	July-Dec 2018 Actuals	CY 2019 Projected	CY 2020 Projected	CY 2021 Projected	Total
Employee Salary/Wages	\$251,428.00	\$0.00	\$0.00	\$65,661.00	\$30,961.17	\$46,802.41	\$55,585.84	\$55,585.84	\$27,792.92	\$251,428.00
Employee Benefits	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Consultants	\$57,000.00	\$0.00	\$0.00	\$0.00	\$9,500.00	\$0.00	\$22,800.00	\$22,800.00	\$11,400.00	\$57,000.00
Equipment	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Supplies (sum of lines below)	\$12,600.00	\$0.00	\$0.00	\$4,436.00	\$1,360.67	\$0.00	\$3,265.60	\$3,265.60	\$1,632.80	\$12,600.00
Educational		\$0.00	\$0.00	\$0.00						\$0.00
Medical/Lab/Pharmacy		\$0.00	\$0.00	\$0.00						\$0.00
Office	\$12,600.00	\$0.00	\$0.00	\$4,436.00						\$4,436.00
Travel (mileage/parking expenses)	\$41,176.00	\$0.00	\$0.00	\$731.00	\$6,740.83	\$417.02	\$16,011.19	\$16,011.19	\$8,005.60	\$47,916.83
Occupancy	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Current Expenses (sum of lines below)	\$412.00	\$0.00	\$0.00	\$412.00	\$0.00	\$663.78	-\$265.51	-\$265.51	-\$132.76	\$412.00
Telephone	\$412.00	\$0.00	\$0.00	\$412.00		\$138.84				\$550.84
Internet costs	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Postage	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Printing and Copying	\$0.00	\$0.00	\$0.00	\$0.00		\$524.94				\$524.94
Audit and Legal	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Insurance	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Board Expenses	\$0.00	\$0.00	\$0.00	\$0.00						\$0.00
Software	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Marketing/Communications	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Staff Education and Training	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Subcontracts/Agreements	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Other (specific details mandatory):	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Recruitment Fees		\$0.00	\$0.00	\$0.00						\$0.00
Sign-on Bonus		\$0.00	\$0.00	\$0.00						\$0.00
Staff Referral Bonuses		\$0.00	\$0.00	\$0.00						\$0.00
Relocation Expenses		\$0.00	\$0.00	\$0.00						\$0.00
Student Loan Repayment/Reimbursement		\$0.00	\$0.00	\$0.00						\$0.00
Employee Recognition/Retention Bonus		\$0.00	\$0.00	\$0.00						\$0.00
CMEs/Professional Development		\$0.00	\$0.00	\$0.00						\$0.00
Professional Development Fees/Dues		\$0.00	\$0.00	\$0.00						\$0.00
Staff Licensing/Certification Supervision Stipend		\$0.00	\$0.00	\$0.00						\$0.00
Other: please specify below	\$254,641.00	\$0.00	\$0.00	\$10,686.00	\$40,659.17	\$7,182.48	\$94,709.01	\$94,709.01	\$47,354.50	\$254,641.00
<b>TOTAL</b>	<b>\$617,257.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$81,926.00</b>	<b>\$89,221.84</b>	<b>\$55,065.69</b>	<b>\$192,106.12</b>	<b>\$192,106.12</b>	<b>\$96,053.06</b>	<b>\$617,257.00</b>

## 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. The DLA is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses. This tool will replace the ANSA as the organization's CCSA tool in early 2019.
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 Form - Currently, referrals come in through the Central Intake (CI) Department, through the CI Scheduling (phone/walk-ins) and/or through CI Clinicians. CI Scheduling collects the following information from the consumer: demographics, contact information, insurance status. They then provide the consumer with an appointment to come for the intake process with the CI Clinician. When consumer meets with the CI Clinician, they will complete the ANSA, DLA-20 and ASAM criteria tool (TBD).	Current
Referral and Eligibility Screening	Comprehensive Core Standardized Assessment (CCSA) - The 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 will utilize the CCSA tool identified by GNMHC, as outlined in the IDN protocols/guidelines, to be approved by the end of July 2018.	Current
Referral and Eligibility Screening	Adult Skills and Needs Assessment (ANSA) - Completed by the Central Intake (CI) Clinician, this tool determines eligibility for community mental health center (CMHC) services. The tool provides a family history of diseases, substance use, tobacco use, as well as the social functioning and social supports in the consumer's life. If applicable, the CI Clinician recommends treatment services, including IDDT, functional supports, etc.	Current
Referral and Eligibility Screening	Daily Living Activities - 20 (DLA-20) - This tool assesses the individual 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 the following areas: health practices, housing stability, communication, safety and managing time. If applicable, the CI Clinician recommends treatment services, including IDDT, functional supports, etc.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Referral and Eligibility Screening	American Society of Addiction Medicine (ASAM) Criteria Tool (TBD) - If applicable, CI Clinician would recommend treatment services, including: IDDT, functional supports, etc. based upon the individual care needs and risk profile.	Current
Referral and Eligibility Screening	General Guidelines for Transferring Clients from One GNMHC Program to Another Tool/Protocol - If the client is not appropriate for a certain treatment after a period of time, they are transferred to another GNMHC (or IDN) program, using this tool/protocol	Current
Screening and Assessment (Health Indicators)	<p>Health Indicators Screening (TBD) - Implemented through motivational interviewing by the IDDT Nurse, the patient will be screened for:</p> <ul style="list-style-type: none"> <li>• a personal/family history of diabetes, hypertension, and cardiovascular disease</li> <li>• BMI</li> <li>• blood pressure</li> <li>• blood glucose or HbA1c</li> <li>• lipid profile</li> <li>• tobacco use/history</li> <li>• substance use/history</li> <li>• medication history/current medication list with dosages</li> <li>• social supports.</li> </ul>	Current
Screening and Assessment (Mental Health Treatment)	PHQ-2/9? ASI?—Implemented through motivational interviewing by the IDDT Therapist, the mental health screening/assessment will screen the patient regarding their past mental health issues, helping to inform diagnosis and subsequent treatment planning. It will also help the IDDT team determine which bio-psychosocial interventions will best support and promote recovery for the patient.	<del>Under Development</del> Current
Treatment and Management (Strengths and Needs)	Case Management Comprehensive 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.	Under Development— <b>expected to be operationalized in 2019</b>

Protocol Name	Brief Description	Use (Current/Under Development)
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 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 (including 12-step programs) or family therapy, or a combination.
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.
Nurse	Supports medication compliance through administration, monitoring, and educating about medication needed to manage diagnoses and symptoms.

Project Team Member	Roles and Responsibilities
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.
Peer Support Specialist	Provides support to the client through helping the client identify his/her own goals and recognize that not managing their illnesses interferes with attaining their goals.
Supported Employment Specialist	Assists client through a vocational program that stresses competitive employment in integrated community settings and provides ongoing support.
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 for 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				

## ***IDN Community Project: Attachments***

Attachment\_E.1a IDN Level Workforce Capacity Development Implementation Plan: Requirements, Timeline, Milestones and Evaluation Project Plan

Attachment\_E.9: Community Project Training Plan and Curricula

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 Committee 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. Identify 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. Identify/Develop Training and Supervision Plan, Conforming to SAMSA "Training Frontline 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 with Collaborating Organizations, Including Social Service Support Providers	
Complete	A. Identify collaborating organizations	
Complete	B. Obtain signed agreements with applicable collaborating 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 identify 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 monitor (including CMT for Event Notification Service and Shared Care Plan and Kno2 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 well 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	
Complete	A. IDDT Fidelity 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 Fifield	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 with overview of IDN protocols/guidelines	
Complete	D. Staff trained in Cultural Competence and Adaptation	
Complete	D1. Unpacking Assumptions: Staff engaged in learning about how assumptions impact providing health 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 Cultures: 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 Collaborative, 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 Capability 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 Families	
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 consultation 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 with 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 Utilization Milestones (Initiation of Data Reporting) July to December 2017	
Complete	I. Report on number of individuals enrolled (during reporting 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 recruited 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 recruited/retained vs. 7.3 FTEs projected
In progress	III. Report on impact measures as defined in evaluation plan, including annual evaluation of fidelity to evidence-supported program elements	Team is still working through indicators and tracking mechanisms
Complete	A. IDDT Fidelity Baseline Assessment completed by Case Western Reserve University	Completed
Complete	Stage 2: Project Utilization 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 recruited and trained (during reporting period and cumulative) vs. projected	
Complete	A. Number of staff recruited/on-boarded vs. projected: 4.8 FTEs recruited/retained vs. 7.3 FTEs projected	
Complete	B. Number of staff trained vs. projected	

attachment\_E.1a:  
IDDT Implementation Plan

In progress	B1. IDDT Fidelity 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 GNMHC. 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 Collective Medical Technologies (CMT) to enable the ability to receive emergency department, urgent care, and inpatient admissions, discharges and transfers (ADTs). Contracting and operationalization steps also completed with Kno2 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 GNMHC 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.

attachment\_E.9:  
IDDT Training Plan

Training/Education Topic	Training/Support Target Timeframe	12/31/17 Progress	06/30/18 Progress	12/31/18 Progress
<b>I. Programmatic Consultation and Readiness Assessment</b>	October - December 2017	Progress met	Progress met	Achieved
A. Complete IDDT Readiness Assessment	September 2019	Progress met	Progress met	Achieved
<b>II. IDDT Program Fidelity: Assessment, Implementation Action Plan Development and Monitoring</b>	December 2017 - December 2020	In Progress	In progress	In Progress
A. Complete Baseline Fidelity Assessment and Share Recommendations for Action Plan	December 2017 - February 2018	In Progress	Progress met	Achieved
B. Develop Fidelity Action Plan	March 2018	N/A	Progress met	Achieved
C. Conduct Formal Action Plan Reviews with Full IDDT Team	every 6 months	N/A	In progress	In progress
C1. Complete Review #1	September 2018	N/A	N/A	In progress: delayed due to contracting with Case Western Reserve University; expected to be completed in early 2019
C2. Complete Review #2	March 2019	N/A	N/A	N/A
C3. Complete Review #4	March 2020	N/A	N/A	N/A
D. Conduct Follow-up Fidelity Assessment	By December 31, 2020	N/A	N/A	In progress
D1. Follow-up assessment conducted to measure progress toward program fidelity	September 30, 2019	N/A	N/A	N/A
E. Conduct Final Fidelity Assessment	By December 31, 2020	N/A	N/A	N/A
E1. Follow-up assessment conducted to measure where program fidelity is near end of DSRIP demonstration	September/October 2020	N/A	N/A	N/A
<b>III. IDDT Team Builds Core Competencies to Ensure Program Fidelity</b>	December 2017 - December 2019	N/A	In progress	In progress
A. IDDT team participates in training to build core competencies	December 2017 - June 2019	N/A	In progress	In progress
A1. Stages of Change Training	By December 31, 2018	N/A	In progress	In progress: Stages of Change 1 and 2 have been conducted; Stages of Change 3 and 4 are expected in early 2019
A2. Motivational Interviewing Training	By December 31, 2018	N/A	In progress	Achieved
A3. Team participates in trainings on patient privacy and consent, including HIPAA and 42 CFR Part 2	By December 31, 2018	N/A	In progress	Achieved
A4. Team participates in Multi-Disciplinary Core Team (MDCT) training on universal screening	By December 31, 2018	N/A	In progress	Achieved
A5. Team participates in Multi-Disciplinary Core Team (MDCT) training on cultural competence and adaptation	By December 31, 2018	N/A	In progress	Achieved
A6. Team participates in Multi-Disciplinary Core Team (MDCT) training on understanding addiction	By December 31, 2018	N/A	In progress	Achieved
A7. Team participates in Multi-Disciplinary Core Team (MDCT) training on care planning and care coordination	By December 31, 2018	N/A	In progress	Achieved
A8. Team participates in Multi-Disciplinary Core Team (MDCT) training on co-occurring disorders	By December 31, 2018	N/A	In progress	Achieved
B. Team participates in both team-based and individual technical assistance with CWRU	December 2017 - December 2020	N/A	In progress	Achieved: calls occur minimally monthly, with team lead and implementation team meeting more often
B1. Team engages in technical assistance calls with Case Western Reserve University	January 2018 - September 2019	N/A	In progress	Achieved and expected to continue through end of demonstration
B2. IDDT Coordinator engages in supervision technical assistance calls with Case Western Reserve University	January 2018 - September 2019	N/A	In progress	Achieved and expected to continue through end of demonstration

## ***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.

Use the format below to: identify the IDNs participation in workgroups for the development of the DSRIP APM Implementation Plan; assess the current use and/or capacity for engaging APMs amount IDN participants; develop an IDN-specific plan for implementing the roadmap to include IDN-specific outcome measures; and develop the financial, clinical and legal infrastructure required to support APMs.

<b>Statewide APM Taskforce and Implementation Plan Activity</b>	<b>Progress</b>	
	<b>As of 6/30/18</b>	<b>As of 12/31/18</b>
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Progress Met: The IDN continues to engage in these meetings.	Not Achieved: The IDN continues to work with stakeholder groups and other work teams as the statewide APM roadmap is finalized.
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures	In progress: As the IDN learns from the statewide meetings, we are sharing this information with our Governance Committees.	Not Achieved: The IDN continues to learn from statewide meetings and sharing information with its Governance Committees as the statewide APM roadmap is finalized.
Develop the financial, clinical and legal infrastructure required to support APMs	In progress: As the IDN learns from the statewide meetings and the other statewide Quarterly Learning Collaborative coming up in fall 2018, we will utilize this information to work with our Governance Committees to develop the infrastructure.	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.

Statewide APM Taskforce and Implementation Plan Activity	Progress	
	As of 6/30/18	As of 12/31/18
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	In progress: As the IDN learns from the statewide meetings and the other statewide Quarterly Learning Collaborative coming up in fall 2018, we will utilize this information to work with our Governance Committees to develop the infrastructure.	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.