New Hampshire
Department of Health and Human Services

Building Capacity for Transformation Waiver

Integrated Delivery Network

Semi-Annual Report

(January – June 2018)

Network4Health (IDN 4)

October 5, 2018

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Project Plan Implementation Narrative

Network4Health remains dedicated to improving the lives and health outcomes of community members who experience behavioral health issues or are at risk of experiencing behavioral health issues. We believe that this can be achieved through the utilization of an integrated approach to care that includes primary care, behavioral healthcare, and community based social services providers who address the social determinants of health.

Network4Health has continued to make significant progress during the period from January 1, 2018 to June 30, 2018. Activities designed to operationalize the Network4Healthproject plans are well underway as described in the following sections of this Semi-Annual Report. As of January 2018, Network4Health had permanent project directors in place for each project. Our Director of Integrated Healthcare started at the beginning of January. In addition, our Workforce Development Coordinator joined our team in April. Recruitment continues for one additional Coach in Care Transitions (C1). Recruitment and hiring of staff for the Expansion of Substance Use Disorder Treatment Options Partial Hospital Program (D3) continues. The program is scheduled to open by October 1, 2018.

Since its inception, Network4Health has worked closely with our two Regional Public Health Networks (RPHNs) - Greater Manchester and South Central. The two RPHN Continuum of Care Coordinators assisted with initial N4H efforts in the areas of community needs assessment and community engagement. In February 2018, when state funding for these positions ended abruptly, the Network4Health Steering Committee approved continuation of these two roles. Job descriptions were updated and the position titles became "Community Outreach Coordinators." Beginning in July 1, 2018, state funding was restored at 50%. Network4Health intends to provide the additional 50% funding so that these important community outreach efforts will continue to occur.

Soliciting Community Input

Network4Health makes a concerted effort to engage in each of the public health regions in which it operates and participate with its partners to improve the health of our communities:

- The **South Central** Public Health Region includes the communities of: Atkinson, Chester, Danville, Derry, Hampstead, Londonderry, Plaistow, Sandown, Salem, and Windham.
- The **Greater Manchester** Public Health Region includes the communities of Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, Manchester and New Boston.

Community engagement sessions were held in both South Central and Greater Manchester between January and July 2018. These sessions were facilitated by each regions' Community Outreach Coordinators in collaboration with Network4Health in the form of focus groups with stakeholders and consumers. Groups were held in the following locations with **82 total participants**:

a. Families in Transition Manchester (7 participants)
b. City Year Manchester (2 groups on 2 different days totaling 26 participants)
c. Derry Friendship Center (7 participants)
d. On the Road to Wellness Derry (7 Participants)
e. NAMI Derry (5 participants)
f. Upper Room (12 participants)
g. Elliot Hospital Patient & Family Advisory Council (18 participants)

For the sessions, we utilized a set of vetted questions to determine changes over past year and continued challenges and barriers from both stakeholders and a client perspective. The specific questions include:

1. In our experience we have heard that people are having a hard time with stigma, cost, long waits for care, care transition problems, integrated care, and lack of providers. We are wondering if you can help us better understand what we are hearing and seeing. Have you experienced this? What was that like?
2. Over the last year or two where does it feel like we are falling behind? Or what are the continued challenges in health and human services care delivery?
3. Over the last year or two where does it feel like we are making progress? Are things getting better?

This qualitative data has proven invaluable to our work and helps us to answer the question 'why' when we look at quantitative data sources and see gaps. Some of the Key Findings/Themes include:

CARE

High cost of care and wait times/ contact problems
Healthcare gaps - between Medicaid and paying for own - high co pays
Long waits for care in general, inpatient beds, and for community mental health services.
Not enough help for patients to get/keep insurance [Medicaid].
Not enough staff (clinicians, social workers, etc.) High turnover. Long stays at a hospital while waiting for an inpatient bed.
Lack of coordinated care

STIGMA & MH

Mental health stigma at ER - perceived feelings of being treated poorly
Stigma still exists and makes it difficult to access services. Stigma can be especially difficult for people of different cultures
Mental illness prejudice at PCP
Some PCP's think that individual with mental illness is just drug seeking. Private practices are denying people with severe mental illness and being turned away.
People leave PCP because of negative comments about MH

INTEGRATION

You must do all the coordination work on your own
Wait times during care transition
Lack of places to get sober during transitions
There was no follow-up from hospital after discharge. Not enough communication from hospital about discharge plan
There is a lack of communication between services: hospital diagnosis didn't make it to mental health center.

SUCCESSES

Places with child care work great (e.g., FIT)

Positive moves in services and technology

There has been an increase in hospitals wanting to hire individuals in recovery so they can both better educate the other staff and relate to the patients coming in with substance misuse disorders. Parkland has opened their behavioral health wing. Community Narcan trainings are happening

PUBLIC AWARENESS –

There is more peer to peer groups.

ACT Team is very positive ("The whole idea of the ACT team is tremendous.")

Network4Health created its own **YouTube channel** during this reporting period. Initial videos are focused on describing the 6 core projects and a 7th video describes the overall waiver and Network4Health. The videos are interview style with each of the six project directors and Executive Director [redacted]. This is a helpful way for partners to learn about the work through a grassroots, no cost effort. Three videos have been completed since January including workforce development, co-occurring disorders and HIT. 2 interviews were completed for Network4Health generally and one for integration core project and scheduled interviews for 2 additional videos - Care Transitions and PHP– will be completed by September 30th. In addition, Network4Health further expanded its s**ocial media** by standing up both a Facebook and Twitter page and began following our 40+ partner organizations. While our social media presence is still in its infancy, we anticipate using these platforms to regularly update partners on project progress and health promotion.

The **Network4Health Website** went live in December of 2017. Shortly thereafter, it became apparent that the platform that had been used to create the website had limitations that prevented some customizations that Network4Health desired. During this reporting period, the Network4Health Technology Director to convert the website to the new platform and has made a number of important advancements scheduled to go live on August 1 including:

- Incorporated google translate to allow for translation to languages other than English;
- added an activities calendar linking to both future and past events and links to all supporting documents or registrations,
- added project pages with full project content and detail,
- added staff bios, and a back-end employee site,
- implemented SharePoint functionality,
- include community outreach content and sound and video; and
- improve partner links, search ability and contact us functionality.

Community Compass updates – our online regional resource guide includes urgent help, healthcare, behavioral health, prevention, intervention, treatment and recovery supports (see www.communitycompassgmr.org). This quarter the guide was updated to include all South Central resources in addition to Greater Manchester. The guide was also updated to list partner agencies with services addressing social determinants of health including education support, shelter & housing, employment, finance, food, social services, family supports, etc.

State behavioral health 10 year plan taskforce – In 2008, NH DHHS, providers and behavioral health advocates worked collaboratively to create the first ever NH Behavioral Health 10 year plan. This plan outlined multiple goals for improving the state's system of behavioral healthcare delivery system. Despite great aspirations and efforts, the economic downturn that occurred at the time of the publication of the report hindered ability to achieve many of the goals. In this 10th anniversary year, NH DHHS has embarked on an initiative to create a new 10 year strategic plan. The Network4Health Executive Director and Integrated Treatment of Co-Occurring Project Director have each served on planning taskforces- Operations/Finance and Outpatient Treatment workgroups, and through these workgroups have been advocating alignment of the 10 year plan with the goals of the state's Transformation Waiver.

Hillsborough Coalition on Mental Health and Justice – This longstanding community meeting includes representatives of providers, judiciary, law enforcement, corrections and community advocates. Both Network4Health and the Region 3 Integrated Delivery Network maintain membership. N4H Executive Director and Care Transitions Director attend these quarterly meetings.

Community of Care Work Supported by Network4Health and/or its partners :
Greater Manchester Happenings:

- **Manchester Mayor's Council on Prevention, Treatment and Recovery** –Manchester Mayor [redacted] announced in January 2018 that Network4Health partners and steering committee members, [redacted], Department of Health, Elliot Health System Vice President [redacted] and Catholic Medical Center Vice President [redacted] will co-chair the Mayor's Council on Prevention, Treatment and Recovery. [redacted], Executive Director of Network4Health and [redacted], Community Outreach Coordinator, have been asked to join the Council along with [redacted] of Granite United Way and [redacted] of NH Charitable Foundation. The Council contracted with the Community Health Institute to complete the Calculating Adequate Systems Tool (CAST). Manchester is the only city in the nation that we know of to complete a substance misuse services needs assessment using the SAMHSA evidence-based CAST. This tool has been published and peer reviewed. The city level approach is groundbreaking. This tool showed the city of Manchester to be in the **highest-risk category** and to be in need of additional supports and services across the continuum of care. A community action plan is being developed and is expected to roll out this fall.
- **EmpowerYOU Community Learning Series** – Network4Health is a co-sponsor of the EmpowerYOU Community Learning Services, and since January there have been 6 sessions of the learning series. These sessions are free, open to the public, no registration required, held in a local art gallery and presented by our trusted partners. The topics in 2018 have include Language and Stigma, Building Community Resilience, Overdose Prevention and Response, Treatment & Peer Supports, Advocacy 101 and Addiction & Suicide Prevention. For each session we also record a podcast with the presenter to reach a wider audience and we create a "10 things you can do" sheet for each presentation to share widely on social media and other platforms to help empower our community members to be a part of the solution. Podcasts and 10 things handouts can all be found at www.makinithappen.org
- **Manchester Safe Station** - Greater Manchester Community Outreach Coordinator helps to coordinate community meetings for the **Safe Station** program including a data workgroup that

has created a unique identifier that is both HIPPA and CFR 42 part 2 compliant so that participants can be tracked from the fire station access point to case management, level of care assessment, stabilization unit and treatment. This has been an ongoing partnership across Manchester Fire Department, Granite Pathways, Dartmouth and Farnum Center. Additional SafeStation partners participate in community meetings to examine the data and talk through challenges and solutions including Healthcare for the Homeless, Catholic Medical Center, American Medical Response, Elliot Health Systems, Office of the Mayor, Manchester Health Department, Makin' It Happen, Mental health Center Greater Manchester, and Families in Transition.

- **Community response to the closing of Serenity Place** - Serenity Place going into receivership and ultimately closing after 40 years of operations in the community was an enormous hurdle for Greater Manchester. Many of our partner organizations stepped up to aid the city in a solution. Serenity Place was seeing an enormous number of clients, especially through the city's Safe Stations program. Splitting the services among various providers showed that a community response was needed and no single agency could serve this massive number of people seeking help in Manchester. Elliot Hospital took over Drug Court as well as increasing its role in the expansion of partial hospitalization program through Project D3. Granite Pathways was able to begin operating in Manchester as the regional access point and a place for screening and case management for Safe Station participants. Farnum Center created a Stabilization Unit to assist in a need for treatment and safe, sober living while waiting for an assessment and to placement at the appropriate level of care. Families in Transition began operating Lin's Place and Tirrell House the Transitional Living Programs formerly run by Serenity. Partner organizations came to multiple community meetings to make difficult decisions on where programming should land and to really think through how to best serve our community.
- The Greater Manchester Community Outreach Coordinator sits on the **Manchester Recovery and Treatment Center** project review committee member – this project is focused on co-locating services from Hope for NH Recovery, Mental Health Center of Greater Manchester, Families in Transition and Healthcare for the Homeless at 293 Wilson Street in Manchester. Hope and the Mental Health Center are currently in their space and Families in Transition is expected to begin operations in the space this fall. Healthcare for the Homeless is a newer addition and will operate a clinic including Medication Assisted Treatment services – anticipated 2019.
- The Community Outreach Coordinator facilitates the **Greater Manchester SUD Collaborative** - the Collaborative is a group of providers across healthcare, prevention, intervention, treatment and recovery. The group is largely on the ground providers working in day to day delivery of direct services. This group follows Safe Station and IDN updates each month to understand changes, challenges and progress. This group works to identify gaps, needs and barriers for their clients, themselves and their organizations and looks to find creative solutions. The group met six times this quarter including inviting advisors from the Governor's Office to meet with the group and Manchester's Mayor to meet with the group as well. Participants self-report that they are more likely to understand the quickly changing SUD landscape because of their attendance and that they are more likely to make referrals to providers whom they have met and seen the facility. Already many providers have developed relationships with each other through this

collaborative.

The Collaborative has formed several workgroups around prevention, treatment and recovery. These workgroups meet as often as needed. This quarter the workgroup that met often was the treatment workgroup that has been focused on creating a SUD Data dashboard across the continuum. Shared data with partners helps us to identify priority need and to invest time and resources appropriately and make data driven decisions. Over time we hope to build out the dashboard to assist in results based accountability. Our program measures should map up to impact health indicators. Community Outreach Coordinator held two **Screening, Brief Intervention and Referral to Treatment (SBIRT)** meetings this quarter with IDN partners to discuss where SBIRT is already being implemented, where it could be expanded or rolled out, workflows for various implementation sites, etc.

Youth Collaborative - The SUD Collaborative has continued to grow and the need arose for a separate youth focused collaborative. This group includes youth serving providers in prevention, intervention, treatment, recovery, and healthcare. Office of Youth Services, Manchester School District SAPs, NH Healthy Families, Beacon Health Options, NH Children Behavioral Health Collaborative, Manchester Public Library, Weed and Seed Program, Manchester Health Department, DCYF, are examples of attendees. This group met 6 times this reporting period and has worked to complete a prevention inventory, a logic model describing the short and long terms goals of the group and the vision and specific action steps for learning more about the youth treatment needs in Manchester.

- **Overdose Prevention and Response pilot project** with the Center for Disease Control (CDC) and the National Association for County and City Health Officials (NACCHO), includes writing a community action plan and ongoing work with the National Resource Center for Academic Detailing. – Manchester has been selected as one of 4 pilot sites across the entire country as part of this project, and has received special funding to implement new strategies across the community to improve outcomes for patients who use opioids. In partnership with the Manchester Health Department, representatives from Catholic Medical Center, the Elliot Health System, and Network4Health were trained in Academic Detailing and are focused on 8 key messages: (1) Offer Treatment for Opioid Use Disorder (OUD), including MAT, (2) Get Waivered to Prescribe Suboxone, (3) Use Non-Opioid Treatment, (4) If Opioids Must be Prescribed, Start Low, (5) Review the State PDMP, (6) Behavioral Health Services, (7) Stigma Around MAT and SUD Treatments, (8) Knowing where to refer. The 5 academic detailers in our region conducted 51 visits this quarter. This pilot project also requires each of the four project sites to complete a community action plan focused on overdose prevention and response. Manchester's plan includes the following five strategies: (1) Reduce stigma and increase community knowledge and access points (2) Data driven decision making and result-based accountability (3) Increase linkages to care and expand capacity for treatment including Medication Assisted Treatment (4) Funding and sustainability (5) Investigate harm reduction strategies. Community Outreach Coordinator has been very involved to the implementation of this project including on detailer check-in calls and co-authoring the community action plan.
- Manchester submitted an application to the National League of Cities and was selected as one of six cities across the nation to send a team to the **Mayor's Opioid Institute**. The Manchester team traveled to Boston in May 2018 to attend. The team included Mayor [redacted], Health

Director [redacted], Community Outreach Coordinator [redacted], Fire Chief [redacted] and Governor's Advisor [redacted]. This institute helped the city team to frame our current efforts, receive feedback, and learn about other communities' approaches to addressing addiction in their communities. A core faculty of experts were in attendance as well as philanthropic organizations. The city continues to engage in a 12-month technical assistance period with the institute which allows the team to utilize experts from around the country to help advise our efforts.

- School department **TREE grant and Mental Health Awareness Training Grant** letters of support – Network4Health submitted letters of support for two Manchester School Department grant applications. One grant, M-AWARE, focuses on saturating the community with Youth Mental Health First Aid. The need for consistent and coordinated training for youth serving professionals has been identified in the Continuum of Care Development Plan in the region and is a focus of Makin It Happen's future plans to support our Youth Collaborative organizations. If the district is awarded this grant it would quickly forward some of those goals and may be a catalyst for other training and education gaps as well. The second grant application is the TREE grant. This grant focuses on expanded capacity of youth treatment for SUD and co-occurring disorders and increasing referral patterns including screening and intervention within the schools. Again, youth services for substance misuse were identified as lacking across the continuum of care during the assets and gaps scan and development plan work.
- Greater Manchester Community Outreach Coordinator is a **NH Providers Association** board member. - The provider's association represents alcohol & other drug service providers in New Hampshire through public policy, leadership, professional development, and quality member services.
- This quarter the Community Outreach Coordinator was accepted into **Leadership Manchester** class of 2019. This program has an excellent reputation for expanding knowledge of the resources and assets in the region as well as the greatest challenges and creating lasting connections across public, non-profit and business sectors.
- The Community Outreach Coordinator presented to **NH Library Directors** (of communities with greater than ten thousand residents) to discuss the scope of the addiction epidemic and how libraries can be part of the solution.
- The Community Outreach Coordinator facilitated a panel of SUD treatment providers and advocates for the Southern NH Planning Commission Legislative Breakfast.

<u>South Central Happenings:</u>

- **South Central Leadership group** - The South Central Leadership Team has met twice during 2018. The first meeting was on May 5th with about 15 participants at the Salem Boys and Girls club. The participants from this meeting represented business owners, coalition leaders, teachers, individuals who work for a mental health center, and individuals who work with youth. The meeting is a collaboration with the South Central Substance Misuse Prevention Coordinator. The second meeting was held on June 25th with 16 participants at the Community Alliance for Teen Safety in Derry. Some participants were the same from the first meeting. New individuals included members for Derry fire/EMS and Londonderry Police Department. Both meetings included time to discuss the projects that the public health network was doing, a highlight from

a service provider (meeting 1 was the boys and girls club, meeting 2 was Aware Recovery Services), and time for cross-sharing.

- **Mental health taskforce** – [redacted], a pediatrician at Londonderry Pediatrics, first began this group because of the strong response that was given for an event held in Derry. This event was held at one of the schools in Derry and included [redacted] speaking on his experiences. From this, [redacted] pulled together some of the participants from this event (Parkland Medical Center, Community Alliance for Teen Safety, Center for Life Management, and Hampstead Hospital) to create a taskforce of sorts to continue the conversation of who mental health services could be improved. Several other people have joined in since the first meeting including the Derry Town Council, the IDN, and the public health network. The first meeting was held in April and has continued monthly. There are usually ten people who come to each meeting. Much of the conversation has been centered around gaps and what some organizations are doing to combat that. At one meeting Center for Life Management was asked to speak about the services they provide and who is eligible and at another meeting the IDN was asked to speak on the different priorities and subcommittees are doing.
- **Risky Business event-** Collaboration with Stand Up Salem. The South Central Community Outreach Coordinator led the prevention week subcommittee. Then planned the event which brought Melissa Fernald to the area to do her presentation. 40 parents came to the event on May 17th at Woodbury School in Salem. The presentation was the mock bedroom set-up and the presenter went on to talk about the current trends among youth including marijuana, vaping, and alcohol. She was talked about how to have difficult conversations with youth and what parents need to watch out for as warning signs.

Network Development

Serenity Place is no longer a Network4Health partner as a result of its closure in December 2017.

Fusion Health Services joined as a network partner during the reporting period. Fusion is a provider organization that targets integrated services to individuals struggling with addiction. Fusion's mission, vision and priorities were recognized as being well aligned with Network4Health priorities.

Network4Health held its quarterly all network partners meetings on March 1, 2018 and June 7, 2018. Our March meeting included brief updates on implementation progress and a featured presentation on integrated practice by Cherokee Health Systems in Tennessee. Our June meeting included comprehensive updates by all project directors on progress in the current reporting period ending June 30, 2018. Two network partners- Manchester Community Health Center and The Mental Health Center of Greater Manchester- provided detail on organizational Integration Enhancement Plans with support of Network4Health. The June meeting time was extended to offer partners the opportunity to network and share information.

Addressing the Opioid Crisis

Network4Health has participated in multiple community initiatives that are focusing on elements of the opioid public health crisis. These efforts are described in detail in the Soliciting Community Input section above.

Governance

The Network4Health Steering Committee met monthly throughout the reporting period and continues to provide oversight of project plan development, implementation and budgeting. There have been no membership changes. The Steering Committee approved one new network partner during the reporting period - Fusion Health Services.

At the May meeting, the Steering Committee agreed to begin a strategic planning initiative that would explore Network4Health sustainability beyond the waiver period. Consideration will be given to the experiences of others around the country as well as other NH based initiatives that may have relevance for our network, including but not limited to Medicaid Managed Care re-procurement, new federal government support for substance use disorder prevention and treatment as well as the future of long term supports and services in New Hampshire.

Bailit Health, our consulting firm who has assisted Network4Health from the beginning, has been engaged to facilitate this strategic planning process. Future Steering Committee meetings will include focused time to continue this planning. Our goal is to have a draft strategic plan by the fall of 2018.

Monitoring Progress

Network4Health monitors progress on meeting our network and the Department's goals on an ongoing and regular basis. The table below provides implementation activities and milestones, the responsible party within Network4Health, the timeframe for the activity and progress measures. Each of the activities delineated below will be ongoing throughout the course of the demonstration. As noted above, community engagement activities are extensive. In terms of network development, Network4Health will monitor its membership on a regular basis and will assess potential new network partners. To retain current membership and keep them engaged, quarterly all partner meetings are held. The Steering Committee meets monthly and provides governance for the network.

Implementation Activity/Milestone: Community Input	Responsible Party/Organization	Timeline	Progress Measure/Notes
In partnership with the Greater Manchester and South Central Regional Public Health Networks, Network4Health will coordinated and participate in community/organizational meetings to elicit community input and engagement.	N4H Executive Director/N4H Community Outreach Coordinators	Attend 6 outreach meeting over the six month reporting period.	8 meetings have been held during the reporting period. Results are summarized in the Soliciting Community Input section of this report.
Implementation Activity/Milestone: Network Development	Responsible Party/Organization	Timeline	Progress Measure/Notes
Continue to consider whether new partners	N4H Executive Director	Quarterly	Quarterly review of partners and potential for new members. One new

should be invited to join Network4Health			partner- Fusion Health Services- was added.
Hold quarterly all partner meetings	N4H Executive Director	Quarterly	Quarterly all partner meetings were held in March and June.
Implementation Activity/Milestone: Addressing Opioid Crisis	Responsible Party/Organization	Timeline	Progress Measure/Notes
Participate in ongoing community activities and presentations on the Opioid crisis.	N4H Executive Director, N4H Community Engagement Coordinators, and N4H partner organizations	Quarterly	Network4Health was involved in several activities during the reporting period. Details are provided in the Soliciting Community Input section.
Participate in Continuum of Care Meetings	N4H Executive Director, N4H Community Engagement Coordinators, and N4H partner organizations	Monthly (Greater Manchester) and Quarterly (South Central)	Network4Health was represented at monthly and quarterly meetings by one or more representatives.
Implementation Activity/Milestone: Governance	Responsible Party/Organization	Timeline	Progress Measure/Notes
Hold monthly meetings of the N4H Steering Committee	N4H Executive Director	Monthly	Monthly meetings of the Network4Health Steering Committee were held.

Budget

Network4Health has adopted a fiscally conservative approach to utilization of Project Design and Capacity building funds received in the first year operation. These funds support the salary and benefits of the Executive Director (1.0 FTE), the Financial Coordinator Manager (1.0 FTE), Project Managers (1.6 FTE), Project Directors for Care Transitions, SUD Expansion PHP and Integrated Treatment of Co-occurring Disorders (up to 3.0 FTE) and Community Outreach Coordinators (2.0 FTE during this reporting period and reducing to 1.0 fte beginning July 1, 2018).

Project plan funding continues to emphasize limited administrative overhead and maximum funding directed to impacting patient/client services. However, there are administrative expenses that planned, budgeted and approved by the Steering Committee. These included but are not limited to consulting support, administrative support for leadership, implementation expenses associated with community engagement, website and other promotional development for the network, among others.

The budget below provides a detailed description of how Network4Health intends to utilize its Project Design and Capacity Building Funds over the course of the demonstration. Modifications made since the last reporting period include:

Network4Health has learned from NH DHHS officials that the final payment of “Transformation Funds”, if earned, will likely not occur until May or June of 2021. Thus, we have adjusted our budget to reflect some continued operations during that time period.

Support for Community Engagement Coordinators were added to the Network4Health budget beginning in February due to the discontinuation of the Regional Public Health Network Continuum of Care Coordinator funding. These two individuals have been instrumental in all N4H community engagement efforts.

Additional consulting expenses were incurred due to needs in the areas of privacy, data sharing/reporting and strategic planning.

The Steering Committee Project Team Support has been adjusted for purposes of rebalancing our full waiver term projections. Our total expensed for this reporting period was $260,955 (this figure represents paid invoices only. Other expenses for the period are anticipated and included in the projections for the July to December time frame). Total invoiced and paid expenses for Project Design and Capacity Building since inception is $851,543.

PROJECT DESIGN AND CAPACITY BUILDING	CY 2016 (Yr1)Actual (7/1/16 to 12/31/16)	CY 2017 (Yr2) Actual	CY 2018 (Yr 3) January to June Actual	CY 2018 (Yr3) July to December Projected	CY 2019 (Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) 1/1/21 to 6/30/21 Projected
Total Revenue (received in two payments)	$ 5,216,890						
Rollover		$ 5,149,331	$ 4,626,302	$4,365,347	$3,256,843	$ 1,897,384	$ 522,427
Total Revenue	$ 5,216,890	$ 5,149,331	$ 4,626,302	$4,365,347	$3,256,843	$ 1,897,384	$ 522,427
Salary & Benefits-Executive Director (1.0 fte); Project Management (1.6 fte); Finance Coordinator (1.0 fte); Data Analyst (1.0 fte in 2017); Community Project Directors (3.0 fte); Community Engagement Coordinators (1.0 fte)		$ 473,355	$ 247,793	$ 512,166	$ 759,959	$ 785,457	$ 380,500
Consulting							
Bailit Health	$ 67,559	$ 40,834	$ 11,066	$ 33,934	$ 45,000	$ 35,000	$ 15,000
UNH Law Health Practice & Policy Institute Privacy Consult		$ 5,500					
Privacy Legal Consult				$ 10,000			
Total Consulting		$ 46,334	$ 11,066	$ 43,934	$ 45,000	$ 35,000	$ 15,000
Steering Committee Project Team Support and other N4H administrative support.		$ 1,826	$ 543	$ 544,457	$ 545,000	$ 545,000	$ 122,000
Quarterly Partner Meetings-refreshments		$ 1,226		$ 6,000	$ 6,000	$ 6,000	$ 3,000
Miscellaneous Office Supplies		$ 289	$ 1,553	$ 1,947	$ 3,500	$ 3,500	$ 1,750
Total Other		$ 3,340	$ 2,096	$ 552,404	$ 554,500	$ 554,500	$ 126,750
Subtotal	$ 67,559	$ 523,029	$ 260,955	$1,108,504	$1,359,459	$ 1,374,957	$ 522,250
Variation to Budget (Transfer Funds to Subsequent Year)	$ 5,149,331	$ 4,626,302	$ 4,365,347	$3,256,843	$1,897,384	$ 522,427	$ 177

Project A1: Behavioral Health Workforce Capacity Development

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

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

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

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

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

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

Network4Health continues to focus on expanding the behavioral health workforce in our region and statewide. The updated Behavioral Health Workforce Plan is included as Attachment_A1.3.

We continue to be an active participant on the statewide Behavioral Health Workforce Taskforce.

Education
Network4Health has several initiatives underway to increase educational opportunities for behavioral health treatment careers in our area, including:

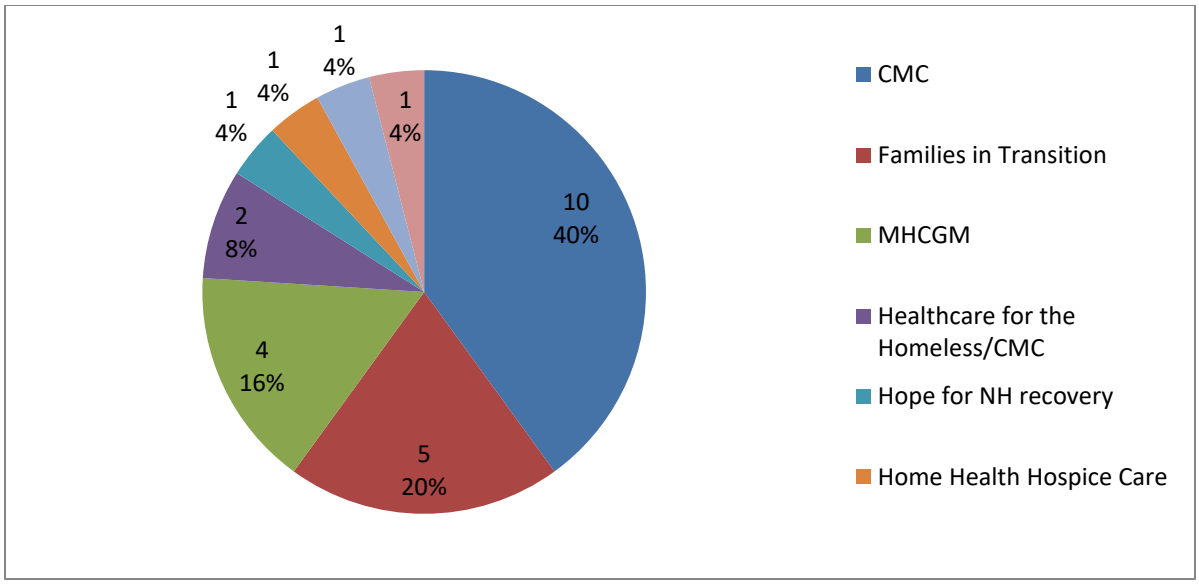
- Development of scholarship programs to begin for the Fall 2018 for students of Granite State College and Manchester Community College (MCC) to support degrees in behavioral health related areas of study such as sociology, psychology and behavioral health sciences. These scholarship funds would augment funding that students currently receive through MCC's HRSA-Funded certificated programs. The scholarship program will be available to either full or part-time students, who are in either an online or traditional program, that have a GPA of 2.5 or

higher and who live in the following towns: Atkinson, Auburn, Bedford, Candia, Chester, Danville, Deerfield, Derry, Goffstown, Hampstead, Hooksett, Londonderry, Manchester, New Boston, Plaistow, Salem, Sandown, Windham. Awards may be up to $5,000, however, based on conversations with Granite State College and MCC, most awards are likely to be smaller as many students are receiving other types of financial aid, including scholarships and Pell grants. The actual award would be based on the gap between current scholarship funding and full cost. Network4Health aims to reduce or eliminate the need for students to take out higher interest loans to finance the remainder of their education. The process will

- Finalized negotiations with Granite State College for a 12-week New Manager Development Program to begin in September 2018. 25 employees of Network4Health partners are registered. The program is focused on high potential staff who either have recently become managers or wish to do so. The program includes both face-to-face and online modalities in the areas of management/leadership, communication, and conflict resolution. Program participants will develop and enhance skills and perspectives that are essential for managers and leaders. This will be accomplished using interactive skill practice, engaged discussion, and other learning methods. All the content will be delivered within the context of understanding some of the unique challenges that working for a mission-driven, non-profit and/or health provider can present. Below is a specific listing of outcomes expected of participants in this program:
  - PART ONE: Fundamentals of Management and Leadership:
    - Learn what effective management/leadership is and is not;
    - Identify tools for creating productivity and building morale;
    - Develop a personal action plan to improve your leadership skills.
  - PART TWO: Effective Communication:
    - Understand how to effectively communicate as a supervisor;
    - Explore tools to help you set and communicate performance expectations;
    - Gain techniques for giving constructive feedback without deflating moral;
  - PART THREE: Learn how to Confidently Handle Conflicts:
    - Understand how to motivate your staff;
    - Identify how to avoid the problems that come with supervising your friends;
    - Learn tools for managing conflict situations pro-actively;
    - Build confidence in holding difficult conversations.

  While the course will not count towards college credit or continuing education units, candidates will receive a certificate of completion if all required assignments are met.

The chart below shows the participants by the Network4Health partner that they work for:



- Network4Health is having conversations with the Community College System of New Hampshire around building behavioral health apprenticeship programs with two of Network4Health's partners.

- Network4Health continues to partner with UNH to promote internship opportunities for their HRSA-funded MSW program; and is partnering with UNH to offer materials and workshops on utilizing Occupational Therapists as a behavioral health care enhancer in integrated primary care settings. Network4Health hosted a call-in session for Q & A with the UNH OT Program Administration, and discussed the potential role for OTs in behavioral health and integrated health environments and how OTs could bill for services.

- Network4Health facilitated Q & A for Manchester Community College's HRSA-funded behavioral health certificate programs with the intent to grow internship slots for students through additional placements with Network4Health partners.

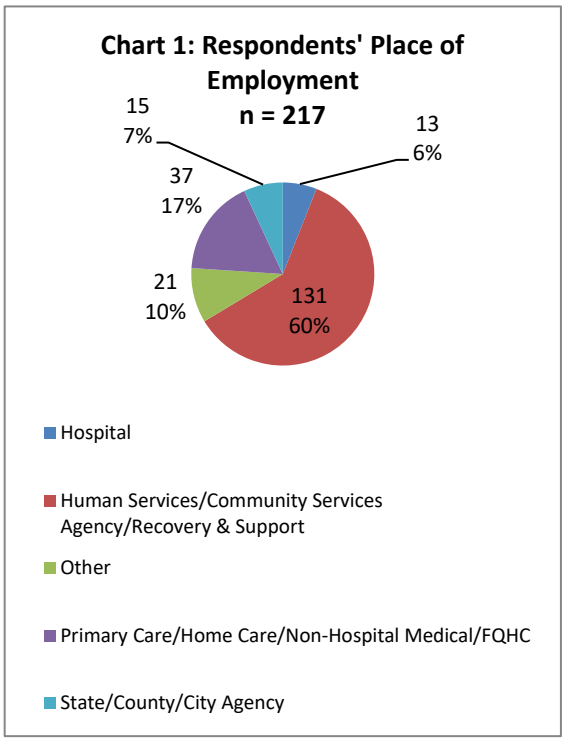
- Network4Health continues to partner with Westfield State University to offer materials and workshops on utilizing Physician Assistants as a behavioral health care enhancer in integrated primary care settings. Based on our efforts, a workshop on the possibility of creating a fellowship program for BH PA's will be presented to B1 partners on July 13, 2018.

- Network4Health visited Operation ABLE, a community-based organization (which is not a Network4Health partner) whose mission is to assist older adults with obtaining employment. They have one specific federally-funded program called SCSEP (Senior Community Support Employment Program) in which qualifying adults work at CBO's or government offices in return for a stipend. This program lasts for 3 years and then participants are transitioned into a regular position. Network4Health funded a Community Health Worker (CHW) training slot for an older woman who is bi-lingual in Spanish. When she completes the training, she will be qualified to find a position as a CHW.

- Network4Health participated in the planning and running of two Behavioral Health Educational Round Tables, occurring in February and April. The February Roundtable brought together behavioral health education programs from across New Hampshire to map the current state of behavioral health education programs; discuss challenges, successes; plans for the future and alignment of programming. The New Hampshire Department of Employment Security (NHES) attended the April Roundtable. Together with our Network4Health partner organizations we discussed the behavioral health labor market in New Hampshire and discussed challenges in placing interns and hiring graduates among other concerns. The next roundtable will occur in October.

- Network4Health conducted an educational assessment to survey educational attainment and readiness of employees of Network4Health partners. An analysis of the 222 responses which we received follows. Chart 1 represents the organizations where respondents work.

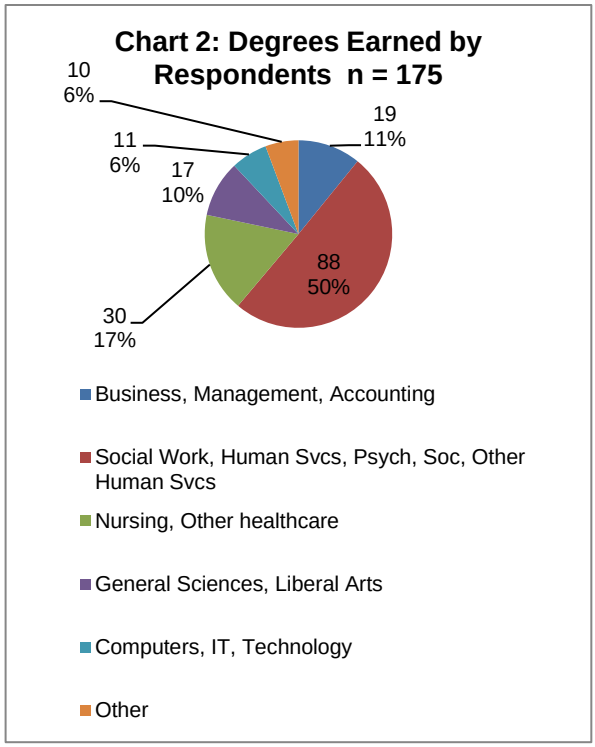
In terms of attainment, nearly 80% of our respondents have Associate degrees or higher, and half of those are in social work or other human service related field (chart 2).

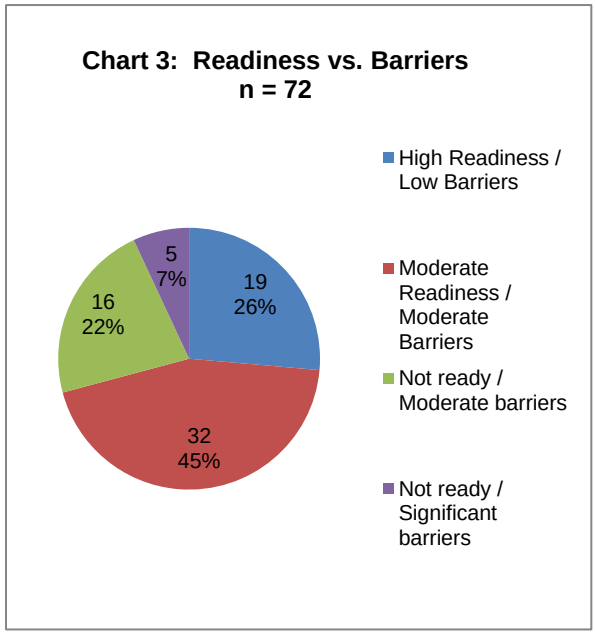


We learned that 10% of the respondents are in school right now, and of the ones pursuing master's level education, 11/12 people are in a behavioral health related field (the other was in nursing).

One important part of our survey was finding out how ready folks are to continue their education – at any level. We asked a series of questions designed to measure the readiness of respondents, and asked them to generalize what types of barriers were preventing them from moving forward in their education. Once we had this data, we aggregated it and categorized folks into four groups:

- High readiness / Low barriers
- Moderate readiness / moderate barriers
- Not ready / moderate barriers





- Not ready / significant barriers

Chart 3 shows the breakdown of the respondents in these categories:

This generated some interesting information. Nearly ¾ of respondents fell into the first two categories. The first group - High readiness / Low barriers – are 50/50 with their intention to return to school, but fortunately they don't see academic readiness as being a barrier for them. In fact, they know what they want to do but they also would benefit from additional coaching or advising, and more than half see money as being a barrier to continuing their education. Most would like to complete their bachelor or master's degree.

The second group - Moderate readiness / Moderate barriers – is nearly 45% of the total respondents for this question. This group also feels like academic readiness isn't a barrier for them and a solid majority know what they would like to do. When it comes to money, more than ¾ of this group consider money to be a barrier or significant barrier, but only 9 responded that having a scholarship would change their mind - which indicates that money isn't the only thing keeping folks out of school. 50% feel that family obligations are also a barrier or significant barrier.

The last two groups are not ready to continue their education and have moderate or significant barriers to doing so. This group has less than bachelor's degrees, feels money, time and family obligations are barriers, report they aren't academically ready. Half of these individuals feel like they would benefit from advising. Overall this group would benefit the most from completing their education which would give them more career mobility, but they are also the furthest away from doing so.

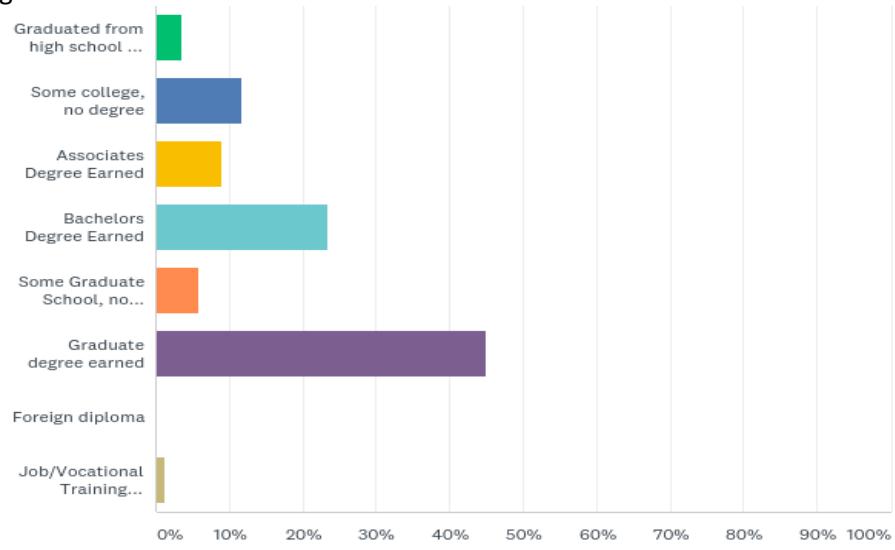
In a broad sense, we can say that we have a well-educated workforce (of those that responded) which is in-line with the demands of most behavioral health roles. However, for those who would benefit from further education, the barriers of time, money and 'knowledge' are still very much present, and Network4Health is working on trying to address those barriers in some way. While we cannot address "time", we can work with potential students to foster a commitment of returning to school.

In terms of money, we have developed and continue to look into additional ways in which Network4Health can utilize its funds for scholarships or similar programs as a way to incent employees to return to/continue their education.

As for 'knowledge,' that's a little more complicated. Knowledge can mean knowledge of career paths or what education leads to what job, but it can also mean academic knowledge or readiness. Network4Health has already created tools to help map the careers and ladders within behavioral health, and this data presents a clear need to create linkages with colleges to help advise potential students on educational paths.

Below are additional charts that outline the results of our data:

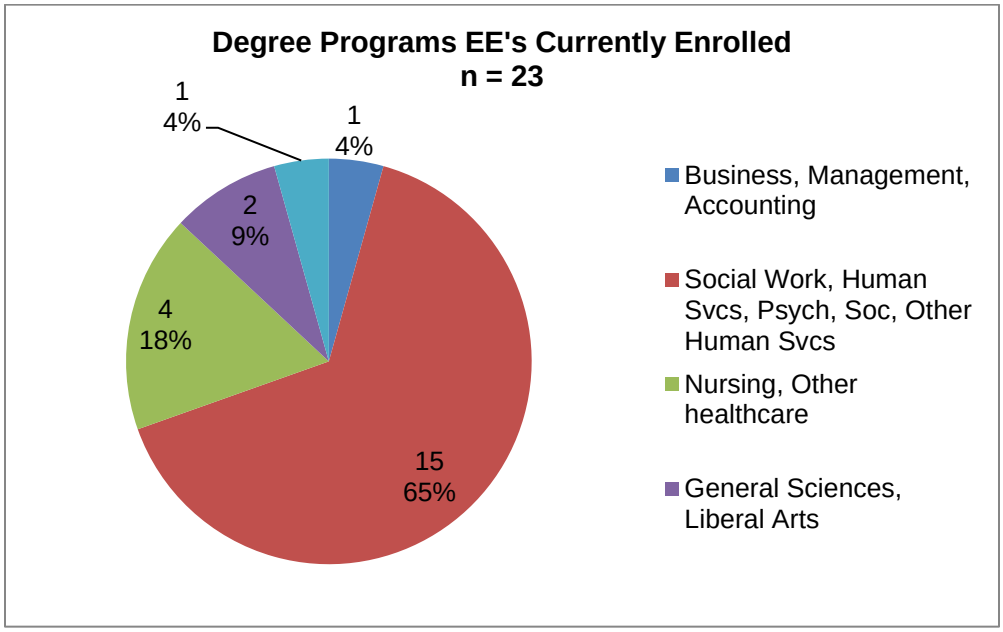
Highest level of education attained



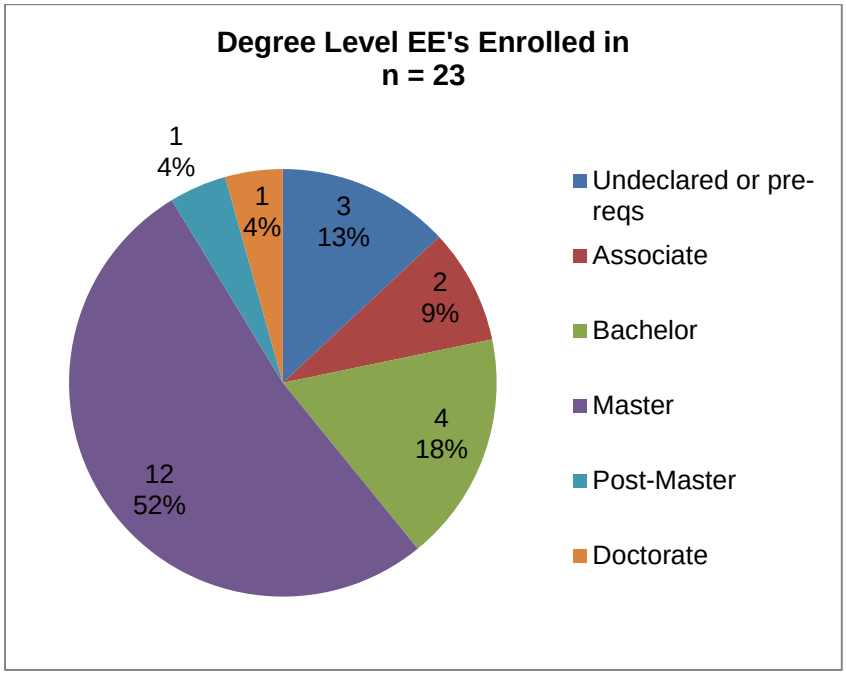
Currently in school?

ANSWER CHOICES	RESPONSES	
Yes	10.41%	23
No	89.59%	198
TOTAL		221

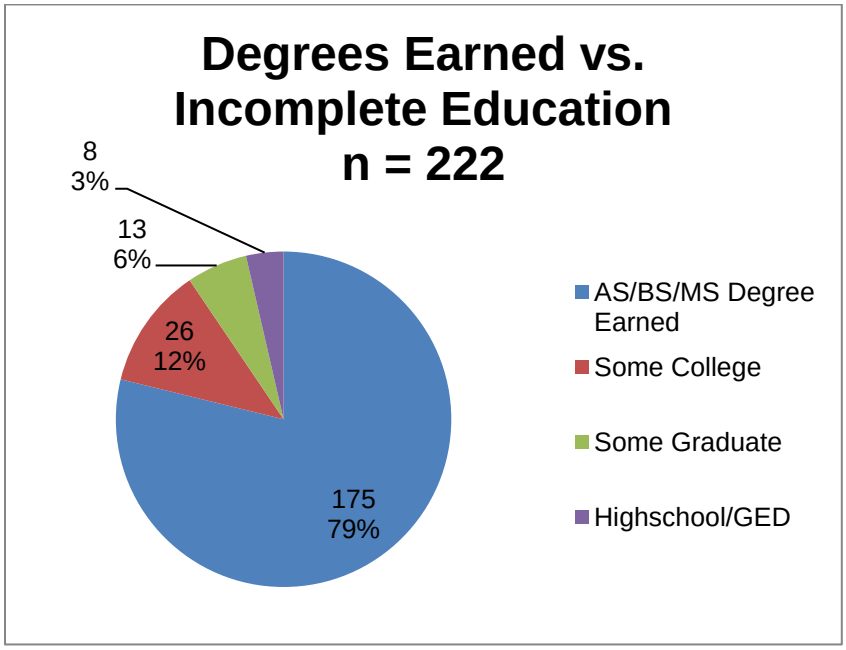
Degree programs employees are enrolled in currently. The majority of our respondents are pursuing a degree in social work, human services, or other related field:



Of those employees currently in school, this chat shows what level of education they are enrolled in. Many are pursuing advanced degrees suggesting that those people are pursuing higher levels of education most likely in social work/human services field:



There are about 1 in 5 respondents who have not completed the education they started out in. These represent a group to target with scholarship funds:



How ready are you to return to school? About 34% of respondents are ready or somewhat ready to return to school:

ANSWER CHOICES	RESPONSES	
Not at all ready	15.15%	30
Somewhat ready	24.75%	49
Ready	9.09%	18
Not sure	14.14%	28
Reached highest education level desired	36.87%	73
TOTAL		198

What are the barriers to you finishing school?

	SIGNIFICANT BARRIER; NOT LIKELY TO CHANGE ANYTIME SOON	THIS IS A BARRIER, BUT MIGHT CHANGE WITH HELP OR PLANNING	THIS IS A MINOR BARRIER FOR ME, BUT I CAN OVERCOME IT MYSELF	THIS IS NOT A BARRIER FOR ME	TOTAL
Academic Readiness - I'm not certain I can handle college level work.	3.39% 4	11.02% 13	16.95% 20	68.64% 81	118
Not sure what degree leads to what job	3.33% 4	16.67% 20	15.83% 19	64.17% 77	120
Money is the main factor holding me back	50.00% 60	18.33% 22	10.00% 12	21.67% 26	120
Family obligations - I'm not sure how to manage my family life and go to school	15.83% 19	27.50% 33	16.67% 20	40.00% 48	120
Time - I work other jobs or have other commitments that leave little time for school	28.93% 35	30.58% 37	22.31% 27	18.18% 22	121
Transportation - I don't have a reliable way to get to a campus consistently	1.67% 2	0.83% 1	1.67% 2	95.83% 115	120

If a scholarship was made available, how likely would that factor into your school plans?

ANSWER CHOICES	RESPONSES	
Very likely	34.71%	42
Likely	24.79%	30
Neither likely nor unlikely	25.62%	31
Unlikely	5.79%	7
Very unlikely	9.09%	11
TOTAL		121

Certificate/degree I would most likely enroll in. This data is interesting because it points to a large number of employees interested in enrolling in graduate degree programs.

ANSWER CHOICES	RESPONSES	
College certificate	3.31%	4
Associates degree	4.96%	6
Bachelors degree	14.88%	18
Graduate degree	31.40%	38
PhD	16.53%	20
Professional certification or credential	11.57%	14
Unknown	17.36%	21
TOTAL		121

Category of employer where you work:

ANSWER CHOICES	RESPONSES	
Hospital (1)	5.99%	13
Primary Care/Home Care/Non-Hospital Medical/FQHC (2)	17.05%	37
Human Services/Community Services Agency/Recovery & Support (3)	60.37%	131
State/County/City Agency (4)	6.91%	15
Other (5)	9.68%	21
TOTAL		217

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	3.00	2.97	0.93

Trainings

Through the A1 project, Network4Health has supported 112 trainings across all projects, with an additional 32 scheduled for the July-December 2018 reporting period. With most trainings, we were able to offer continuing education unit (CEU) credits. In this period, trainings were held in support of the C1 (Critical Time Intervention) and E4 projects (Integrated Treatment for Co-Occurring Disorders) and the B1 Integrated Healthcare project. Specifically, through this project, Network4Health supported the following during this reporting period:

- Trainings for the Care Transitions project include the 2nd CTI Coach Training, monthly CoP meetings facilitated by Hunter College with all 5 regions participating in Care Transitions, and 1:1 coaching support.
- A 2-day training in collaboration with two other IDNs (regions 1 and 6) by senior leaders of the Cherokee Health Systems regarding behavioral health integration. Over 120 individuals participated in the training, including 45 staff from Network4Health partners. This event also provided an opportunity for the 3 regions to network and learn from each other which resulted in immense energy and recommitment to the mission across the region.

During this reporting period, Network4Health has refined and operationalized the EventBrite registration process for our partners and their employees, streamlining registration for paid trainings. In addition, the off-set productivity process has been implemented for organizations that have completed the Integration Enhancement Plan process through B1 Integrated Healthcare Project. Network4Health provides reimbursement, as follows:

Staff Categories	Supported Hourly Offset Rate
Provider (MD, DO)	$200
Physician Assistants and Nurse Practitioners	$100
Clinical Staff and Organization Leadership	$55
Non-clinical Staff	$30

Network4Health also introduced its bi-weekly workforce newsletter, beginning in January 2018. It is the primary tool Network4Health uses to communicate trainings being supported by the A1 project, includes articles on workforce topics, and upcoming information sessions on emerging healthcare and workforce trends, and highlights tools for managers in an effort to promote engagement and retention of employees across the region. Feedback on the newsletter has been positive.

Retention

The Network4Health Workforce Director continues to participate in a number of statewide groups focused on retention, including the Healthcare Sector Workforce Stakeholder Group, the Legislative Commission on Primary Care Workforce Issues, and the New Hampshire Children's Behavioral Health Workforce Development Network.

Recruitment

Network4Health has successfully recruited for 17 of 37 positions. The following describes hiring by project during this reporting period:

- Positions associated with D3 Partial Hospitalization Program were delayed due to the receivership of Serenity Place but have made great strides and have a number of new hires beginning between July -September.
- C1 Care Transitions hired 2 additional CTI Coaches and experienced turnover of 1 Coach in early spring.
- A1 BH Workforce hired [redacted] as our Workforce Development Coordinator ([redacted]) in March. [redacted] is primarily responsible for managing the sponsored trainings Network4Health offers; coordinating training venues and vendors; and providing administrative and logistical support to the A1 project**.** [redacted] brings a wealth of event planning and administrative management skills.
- B1 Integrated Healthcare has hired an innovation consultant, but has decided not to directly hire community health workers, instead B1 will support partner organizations in hiring CHWs through its Integration Enhancement Plans.

In addition, Network4Health introduced a Prescriber Recruitment and Retention Initiative. Through this initiative, Network4Health will reimburse 50% of allowable recruitment/retention costs up to $10,000 to any of our partners who hire or retain a MAT prescriber (MD, DO or APRN).

Network4Health's Workforce Director also researched and wrote a document describing the role differences and hiring standards for CHWs and Patient Navigators. Originally designed to help our partners utilize best practices in defining roles for these positions, the paper has also been shared with all IDNs.

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

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

After careful consideration, Network4Health has removed the following performance measure: "Decrease the 28 open positions for LICSW, LADC and MLADC identified in the 2017 gap analysis". We have found the data on open positions to be inaccurate and a heavy lift for partner organizations; overall the measure was felt to be unreliable. We have previously discussed this decision with state staff who understood or concern with the measure's validity.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Recruit N4H Workforce positions	Up to 37 positions	15	17	
Offer a variety of different trainings across the projects to maintain/improve skills	Up to 144	5	112	

A1-5. IDN-level Workforce: Staffing Targets

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

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Application Analyst	Up to 2	0	1	1	
Integrated Healthcare Clinical Director	Up to 1	0	1	1	
Innovation Consultant	Up to 2	0	0	0	
Community Health Workers	Up to 10	0	0	0	
Co-Occurring Disorders Clinical Director	Up to 1	0	1	1	
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	4 per diem	4 per diem	
Program Coordinator	Up to 1	0	1	1	
Mental Health Clinician	Up to 1	0	0	0	
Substance Use Disorder Clinician	Up to 1	0	0	0	
Clinical Case Manager, BSW, LMA, RN	Up to 1	0	0	0	
Peer Support Specialist	Up to 1	0	0	0	
Nurse	Up to 1	0	0	0	
Psychiatric Nurse Practitioner or Psychiatrist	Up to .06	0	0	0	
Outreach Worker	Up to 1	0	0	0	
Critical Time Intervention Director/Supervisor	Up to 1	0	1	1	
Critical Time Intervention Coach	Up to 6	0	4	5	
Care Transitions Administrative Support Worker	Up to 1	0	1	1	

Behavioral Health Workforce Director	Up to 1	0	1	1	
Behavioral Health Workforce Administrative Support Worker	Up to 1	0	0	1	

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

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

Network4Health's budget for its workforce project is presented below. Modifications have been made based on several factors:

Revenue- All project budgets have been adjusted to reflect the actual receipt or availability of future funding. Previously, our budgets were developed utilizing revenue projections based on the time period for which they could be earned. Revenue for 2018 is being reported in two new columns. The first identifies the actual incentive funding received in May for the July to December 2017 reporting period. It represents a partial payment with the remainder expected soon. The second column, for 2018, projects the receipt of the remaining prior period incentive funding as well as incentive funding anticipated for November. N4H has also added a column for the period of January to June 2021 as we have been informed that our final potential incentive payment would be expected in May or June of 2021.

Expenses- Actual expenses (paid and invoices received) for the period of January to June of 2018 are presented. Anticipated expenses (including those for January to June not yet invoiced) are presented in the column reflecting July to December 2018. Given that final incentive funding is not expected to be received until May or June of 2021, we have projected expenses in that period as we conclude the waiver projects.

Reported actual expenses continue to be below budget due in part to expense reporting that includes only invoiced and paid expenses. Significant training and development funding has been committed to the B1 Integrated Healthcare "Integration Enhancement Plans" that have been negotiated with network partners and plan execution will begin in July. Budgeted recruitment related expenses are expected to escalate with new initiatives soon to begin. Salary and benefit expenses will be increased in the next reporting period as both funded staff positions are now filled.

TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual	CY 2018 (Yr3) January to June Actual	CY 2018 (Yr3) July to December Projected	CY 2019(Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) Projected
A1: BH Workforce (New)	$ 862,544	$ 483,025	$ 1,242,063	$ 1,380,070	$ 875,316	$ 357,796
A1: BH Workforce (Rollover)		$ 825,328	$ 1,228,902	$ 751,182	$ 268,265	$ 2,553
Total Revenue	$ 862,544	$ 1,308,353	$ 2,470,965	$ 2,131,252	$ 1,143,581	$ 360,349
Recruit			$ 600,000	$ 650,000	$ 310,000	$ 120,000
Training/Development	$ 20,527	$ 28,109	$ 1,009,185	$ 988,362	$ 600,000	$ 125,000
Salaries and benefits- Workforce Director (1.0 fte) and Workforce Coordinator (1.0 fte)	$ 14,768	$ 48,509	$ 102,247	$ 213,442	$ 219,845	$ 109,922
Occupancy		$ 2,300	$ 4,600	$ 6,900	$ 6,900	$ 3,450
Technology (Computer, phone, software)	$ 1,921	$ 533	$ 3,751	$ 4,283	$ 4,283	$ 2,140
Subtotal	$ 37,216	$ 79,451	$ 1,719,783	$ 1,862,987	$ 1,141,028	$ 360,512
Variation to Budget (Transfer Funds to Subsequent Year)	$ 825,328	$ 1,228,902	$ 751,182	$ 268,265	$ 2,553	$ (163)

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

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

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Catholic Medical Center (Lead) including Health Care for The Homeless.	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
Catholic Medical Center- Amoskeag Family Practice	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
Catholic Medical Center – Behavioral Health Practice	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**
Catholic Medical Center – Family Health & Wellness at Bedford	**Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider***	**A1, A2, B1, *C1*, E4**

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Catholic Medical Center – Willowbend Family Practice	Hospital, *Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider*	A1, A2, B1, *C1*, E4
American Medical Response of MA	Other	A1, A2
Ascentria Care Alliance	Community-Based Organization providing social and support services	A1, A2
Building Community in NH	Community-Based Organization providing social and support services	A1, A2
Catholic Charities NH	Other, *Non CMHC mental health provider*	A1, A2
Center for Life Management – Behavioral Health	MHC*, SUD*	A1, A2, B1, *C1*, E4
Child and Family Services	Social Services	A1, A2, B1, *C1*, E4
City of Manchester Health Department	Public Health Organization	A1, A2
Community Crossroads	Home and Community Based Care Provider	A1, A2
Crotched Mountain	Community-Based Organization providing social and support services	A1, A2
Dartmouth Hitchcock - Adult Primary Care	Primary Care Provider	A1, A2, B1
Dartmouth Hitchcock – Pediatric Primary Care	Primary Care Provider	A1, A2, B1
Derry Friendship Center	Other	A1, A2
Easter Seals NH, including Farnum Center	Community-Based Organization providing social and support services and SUD Treatment	A1, A2, B1, E4
Elliot Health Systems – Doctors Park Pediatrics	Hospital, Primary care provider, Non CMHC Mental health provider, SUD	A1, A2, B1, *C1,* D3, E4,
Elliot Health System – Partial Hospitalization Program	Hospital, Primary care provider, Non CMHC Mental health provider, SUD	A1, A2, B1, *C1,* D3, E4,
Families in Transition – Family Willows Treatment center	Community-Based Organization providing social and support services, SUD	A1, A2, B1, E4
Fusion Healthcare Services	Primary Care	A1, A2, B1
Goodwill Industries of Northern New England	Community-Based Organization providing social and support services	A1, A2
Granite Pathways	Community Based Organization providing social services and supports	A1, A2, E4
Granite State Independent Living	Home and Community Based Care Provider	A1, A2
Granite United Way	Host Agency for the South Central Public Health Network, Administrative Lead for 211-NH	A1, A2

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Greater Derry Community Health Services, Inc.	Non Profit H&HS	A1, A2
Hillsborough County	County Corrections; Nursing Facility	A1, A2, *C1*
Home Health and Hospice Care	Home and Community Based Care Provider	A1, A2, B1
Hope for NH Recovery	Community Based Organization providing social and support services	A1, A2
International Institute of New England	Other	A1, A2
Life Coping Inc.	Home and Community Based Care Provider	A1, A2
Makin' It Happen	Public Health Organization	A1, A2
Manchester Community Health Center – Hollis Street	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Tarrytown	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Westside Neighborhood Health center	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Community Health Center – Child Health Services	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Housing and Redevelopment Authority	Other	A1, A2
Manchester School District	Other	A1, A2
Mental Health Center of Greater Manchester-	MHC, SUD	A1, A2, B1, C1, E4
NAMI NH	Community Based Organization providing social services and supports	A1, A2
New Hampshire Hospital*	Hospital	A1, A2, *B1, C1*
New Horizons for NH	Community Based Organization providing social services and supports	A1, A2
NH Legal Assistance/NH Medical Legal Partnership	Other	A1, A2
On the Road to Wellness	Non-CMHC Mental Health Provider	A1, A2, B1
Parkland Medical Center	Hospital	A1, A2, B1
Pastoral Counseling Services	Non-CMHC mental health provider, SUD	A1, A2
Rockingham County	County Corrections; Nursing Facility	A1, A2, *C1*
ServiceLink Aging and Disability Resource Center of Rockingham County	Community Based Organization providing social services and supports	A1, A2
Southern New Hampshire Services	Community Based Organization providing social services and supports	A1, A2, E4

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
St. Joseph Community Services, Inc.	**Community Based Organization providing social services and supports**	**A1, A2**
The Moore Center	**Community Based Organization providing social services and supports**	**A1, A2**
The Upper Room	**Community Based Organization providing social services and supports**	**A1, A2**

* New Hampshire Hospital is not an official partner of Network4Health, but will be invited to participate in all trainings offered through the IDN, and will be included in individual projects as appropriate. For example, within CTI, Network4Health will receive referrals from the NHH to the program.

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				

ID		Task Mode	Task Name	Duration	Start	Finish	Resource Names
1			**BH Workforce**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
2			**Recruit**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
3	✓		Recruit 1 BH Workforce Director	132 days	Sat 7/1/17	Mon 1/1/18	BH Workforce Team,Catholic Medica
4	✓		Recruit 1 BH Workforce Administrative Support Worker	132 days	Sat 7/1/17	Mon 1/1/18	BH Workforce Team,Catholic Medical Center
5	✓		Recruit 1 HIT Analyst/Trainer	132 days	Sat 7/1/17	Mon 1/1/18	HIT Team,Catholic Medical Center
6	✓		Recruit 1 Integrated Healthcare Clinical Director	132 days	Sat 7/1/17	Mon 1/1/18	Integrated Healthcare Team,Catholic
7	✓		Recruit 1 Critical Time Intervention Director	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
8	✓		Recruit 1 Care Transitions Administrative Support Worker	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
9	!		Recruit 6 Critical Time Intervention Coaches	132 days	Sat 7/1/17	Mon 1/1/18	Care Transitions Team,MCHGM
10	✓		Recruit 1 Co-occurring Disorders Clinical Director	132 days	Sat 7/1/17	Mon 1/1/18	Integrated TX COD Team,MHCGM
11	✓		Recruit 3 Dual Diagnosis Capability Assessors	132 days	Sat 7/1/17	Mon 1/1/18	Integrated TX COD Team,MHCGM
12	✓		Recruit Program Coordinator (D3)	132 days	Sat 7/1/17	Mon 1/1/18	Expansion of SUD SVCS,Serenity Plac
13	✓		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
14	✓		Assess and evaluate recruitment plan for N4H positions	131 days	Mon 1/1/18	Sat 6/30/18	[redacted]
15	✓		Assess need to recruit 1.5 Innovation Consultants	131 days	Mon 1/1/18	Sat 6/30/18	Integrated Healthcare Team

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Project: BH Workforce PP
Date: Fri 6/29/18

Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

ID		Task Mode	Task Name	Duration	Start	Finish	Resource Names
16	✓		Assess need to recruit 5 Community Health Workers	131 days	Mon 1/1/18	Sat 6/30/18	Integrated Healthcare Team
17	✓		Assess need to recruit Mental Health Clinician	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Plac
18	✓		Assess need to recruit Substance Use Disorder Clinician	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Place
19	✓		Assess need to recruit Clinical Case Manager	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Plac
20	✓		Assess need to recruit Nurse	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Plac
21	✓		Assess need to recruit Nurse Practitioner or Psychiatrist	131 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Place
22			Recruit 1 additional HIT Analyst/Trainer if needed	130 days	Mon 1/1/18	Sat 6/30/18	[redacted]
23			Recruit Peer Support Specialist if needed	130 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Plac
24			Recruit Outreach Worker if needed	130 days	Mon 1/1/18	Sat 6/30/18	Expansion of SUD SVCS,Serenity Plac
25	✓		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
26			Assess turnover and additonal recruitment needs of N4H teams	132 days	Sun 7/1/18	Mon 12/31/18	[redacted]
27			Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Sun 7/1/18	Mon 12/31/18	BH Workforce Director
28			Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	
29			Assess turnover and additonal recruitment needs of N4H teams	130 days	Tue 1/1/19	Sun 6/30/19	BH Workforce Director
30			Revise recruitment plan to include additonal positions needed based on most current assessment	130 days	Tue 1/1/19	Sun 6/30/19	BH Workforce Director

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Project: BH Workforce PP
Date: Fri 6/29/18

Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

ID		Task Mode	Task Name	Duration	Start	Finish	Resource Names
31			Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
32			Assess turnover and additonal recruitment needs of N4H teams	132 days	Mon 7/1/19	Tue 12/31/19	BH Workforce Director
33			Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Mon 7/1/19	Tue 12/31/19	BH Workforce Director
34			Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
35			Assess turnover and additonal recruitment needs of N4H teams	130 days	Wed 1/1/20	Tue 6/30/20	BH Workforce Director
36			Revise recruitment plan to include additonal positions needed based on most current assessment	130 days	Wed 1/1/20	Tue 6/30/20	
37			Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
38			Assess turnover and additonal recruitment needs of N4H teams	132 days	Wed 7/1/20	Thu 12/31/20	Wed 7/1/20
39			Revise recruitment plan to include additonal positions needed based on most current assessment	132 days	Wed 7/1/20	Thu 12/31/20	Wed 7/1/20
40			Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	
41			**Trainings**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
42	✓		Confirm training needs of N4H teams	131 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
43	✓		Survey N4H partners to idenify which partners currently offer trainings needed	131 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
44	✓		Develop training plan based on needs, requests and retention efforts	131 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
45	✓		Begin implementation of training plan	131 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
46	✓		Critical Time Intervention worker training for Coaches	131 days	Sat 7/1/17	Sun 12/31/17	Care Transitions Team

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Project: BH Workforce PP
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Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

ID		Task Mode	Task Name	Duration	Start	Finish	Resource Names
47	✓		Critical Time Intervention training for Director	131 days	Sat 7/1/17	Sun 12/31/17	Care Transitions Team
48	✓		Critical Time Intervention Community of Practice meetings	131 days	Sat 7/1/17	Sun 12/31/17	Care Transitions Team
49	✓		Case Western Reserve training	131 days	Sat 7/1/17	Sun 12/31/17	Integrated TX COD Team
50	✓		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
51	✓		Critical Time Intervention Worker training for Coaches	131 days	Mon 1/1/18	Sat 6/30/18	Care Transitions Team
52	✓		Critical Time Intervention Community of Practice meetings	131 days	Mon 1/1/18	Sat 6/30/18	Care Transitions Team
53	!		HIT training in CMT	131 days	Mon 1/1/18	Sat 6/30/18	HIT Team
54	✓		Case Western Reserve training	131 days	Mon 1/1/18	Sat 6/30/18	Integrated TX COD Team
55			Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
56	!		Critical Time Intervention Train-the-Trainer	132 days	Sun 7/1/18	Mon 12/31/18	Care Transitions Team
57	!		Critical Time Intervention Community of Practice meetings	132 days	Sun 7/1/18	Mon 12/31/18	Care Transitions Team
58			Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	
59	!		Critical Time Intervention Community of Practice meetings	130 days	Tue 1/1/19	Sun 6/30/19	Care Transitions Team
60			Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
61	!		Reasses training needs and participation	132 days	Mon 7/1/19	Tue 12/31/19	BH Workforce Director
62	!		Revise training plan based on most current assessment	132 days	Mon 7/1/19	Tue 12/31/19	BH Workforce Director

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Project: BH Workforce PP
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Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

ID		Task Mode	Task Name	Duration	Start	Finish	Resource Names
63			Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
64			Reasses training needs and participation	130 days	Wed 1/1/20	Tue 6/30/20	BH Workforce Director
65			Revise training plan based on most current assessment	130 days	Wed 1/1/20	Tue 6/30/20	BH Workforce Director
66			Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
67			Reasses training needs and participation	132 days	Wed 7/1/20	Thu 12/31/20	BH Workforce Director
68			Revise training plan based on most current assessment	132 days	Wed 7/1/20	Thu 12/31/20	BH Workforce Director
69			Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	
70			**Gap Analysis Assessment**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	
71			Obtain accurate account of open positions for targets found in most recent Gap analysis	132 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
72			Align recruitment plan with targeted positions	132 days	Sat 7/1/17	Sun 12/31/17	BH Workforce Director
73			Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
74			Assess and revise recruitment plan based on feedback from N4H partners	131 days	Mon 1/1/18	Sat 6/30/18	BH Workforce Director
75			Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
76			Discontinue gap analysis	1 day	Sat 6/30/18	Sat 6/30/18	
77			**Statewide BH Workforce**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**	

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Project: BH Workforce PP
Date: Fri 6/29/18

Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

ID		Task Mode	Task Name	Duration	Start	Finish	Resource Names
78	✓		Approve Statewide Implementation Plan	1 day	Mon 7/3/17	Mon 7/3/17	[redacted]
79	✓		Sign attestation agreeing to Statewide Implementation Plan	20 days	Tue 7/4/17	Mon 7/31/17	[redacted]
80	✓		Participate in establishing monthly work team meetings	46 days	Sat 7/1/17	Fri 9/1/17	[redacted]
81	✓		Attend monthly work team meetings as appropriate	132 days	Sat 7/1/17	Mon 1/1/18	BH Workforce Director,[redacted]
82	✓		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop slate of goals, objectives, and activities for 2019 and 2020	132 days	Sat 7/1/17	Mon 1/1/18	[redacted]
83	✓		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17	
84	✓		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	23 days	Mon 1/1/18	Wed 1/31/18	[redacted],BH Workforce Director
85	✓		Attend monthly work team meetings as appropriate	131 days	Mon 1/1/18	Sat 6/30/18	BH Workforce Director
86	✓		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop slate of goals, objectives, and activities for 2019 and 2020	131 days	Mon 1/1/18	Sat 6/30/18	[redacted]
87	✓		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18	
88	!		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	22 days	Sun 7/1/18	Mon 7/30/18	[redacted],BH Workforce Director
89	!		Attend monthly work team meetings as appropriate	132 days	Sun 7/1/18	Mon 12/31/18	BH Workforce Director
90	!		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities and develop slate of goals, objectives, and activities for 2019 and 2020	132 days	Sun 7/1/18	Mon 12/31/18	[redacted]
91			Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18	
92	!		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	23 days	Tue 1/1/19	Thu 1/31/19	[redacted],BH Workforce Director
93	!		Attend monthly work team meetings as appropriate	130 days	Tue 1/1/19	Sun 6/30/19	BH Workforce Director

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Project: BH Workforce PP
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Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

ID	Task Mode	Task Name	Duration	Start	Finish	Resource Names
94		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Tue 1/1/19	Sun 6/30/19	[redacted]
95		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19	
96		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	22 days	Mon 7/1/19	Tue 7/30/19	[redacted],BH Workforce Director
97		Attend monthly work team meetings as appropriate	133 days	Sun 6/30/19	Tue 12/31/19	BH Workforce Director
98		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	133 days	Sun 6/30/19	Tue 12/31/19	[redacted]
99		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19	
100		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	23 days	Wed 1/1/20	Fri 1/31/20	[redacted],BH Workforce Director
101		Attend monthly work team meetings as appropriate	130 days	Wed 1/1/20	Tue 6/30/20	BH Workforce Director
102		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Wed 1/1/20	Tue 6/30/20	[redacted]
103		Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20	
104		Reasses particpation requested by the Statewide BH Workforce and adjust accordingly	22 days	Wed 7/1/20	Thu 7/30/20	[redacted]BH Workforce Director
105		Attend monthly work team meetings as appropriate	132 days	Wed 7/1/20	Thu 12/31/20	BH Workforce Director
106		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	132 days	Wed 7/1/20	Thu 12/31/20	[redacted]
107		Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20	

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Project: BH Workforce PP
Date: Fri 6/29/18

Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
Split		External Tasks		Inactive Summary		Manual Summary		Progress	
Milestone		External Milestone		Manual Task		Start-only			
Summary		Inactive Task		Duration-only		Finish-only			

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

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

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

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

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

Network4Health continues to support all partners to advance technology and to remedy gaps identified through our surveys and the HIT GAP Assessment reported statewide by Myers and Stauffer. Key findings of this process included:

- Electronic Health Record (EHR) adoption, while high among hospitals and mental health facilities, remains low among community-based organizations and substance used disorder (SUD) agencies;
- Sharing of data between organizations is undeveloped; and,
- Integrated referral systems are not in place.

These findings continue to support the evolution of Network4Health's HIT infrastructure plan for the following HIT solutions:

- An Event Notification System (ENS) through Collective Medical Technologies (CMT) to alert interested parties to utilization events, support integration, support implementation of alternative payment models and ultimately reduce unnecessary emergency department usage and inpatient hospital admissions and readmissions;
- Through CMT, Network4Health will also develop a system to allow for the sharing of multi-disciplinary Care Plans across Network4Health partners and visibility to recommended care suggestions to all providers associated with the identified patient. This effort will support improved transitions, integration and implementation of alternative payment models;
- The incorporation of a direct secure messaging platform to support the secure sharing of patient information throughout the Network4Health community. In conjunction with other technologies this will have significant impact to the accuracy and follow up of referrals to support integration of primary care, behavioral providers and community-based organizations;
- Joining IDNs statewide in the implementation of a data aggregation tool through the Massachusetts eHealth Collaborative to support statewide data collection and performance reporting; and,
- Robust data collection software and data storage strategies through the use of PatientLink.

DIRECT Secure Messaging

Network4Health currently has 16 partners who use direct messaging technologies in daily practice. We have identified multiple gaps however in the use of this technology across entities, consistency of use and the sharing and maintenance of direct addresses.

Our current strategy is to promote a more sustainable and cost-effective solution through the use of MedAllies mail. This application will provide a secure method for providers to communicate with health care organizations across the community. Following a secure email paradigm that meets direct specifications and includes a provider directory that supports multiple direct service addresses for any given health care provider, and relationships with any number of organizations and endpoints.

Through MedAllies Mail, our partners can achieve comprehensive reach to the entire community or medical neighborhood, allowing for streamlined transitions of care even with organizations that are paper-based. MedAllies, unlike other suggested solutions offers our partners a low-cost alternative that is easily sustainable for even the smallest of our partners.

Network4Health has also established a project to build a Community Directory of secure messaging addresses to support the accuracy and maintenance of referral systems. Network4Health recognizes that organizations are limited in their ability to collect address data and keeping this data updated is a resource intensive task. With the development of this Community Directory, Network4Health will provide quarterly updates to our partners ensure information within their organizations is easily accurate and comprehensive.

As shown in our Project plan (Attachment_A2.3) we are gearing up to begin implementation of direct messaging to all HIPPA regulated partners of Network 4 Health, and will complete implementation, testing and training before the end of 2018 allowing us to have full referral functionality amongst our community partners.

Collective Medical Technologies (CMT) - Event Notification and Shared Care Planning

As indicated in our project plan, Catholic Medical Center as the Network4Health administrative lead completed IDN level contracting with CMT for both their PreManage ED and PreManage Community products. In addition, Catholic Medical Center as a Network4Health partner, signed a User Agreement with CMT which allowed them to implement a Catholic Medical Center admission, discharge and transfer (ADT) data feed to the CMT platform for notification to partners across New Hampshire. In addition, Catholic Medical Center engaged participation from their emergency department and IT department leadership and decided to make the CMT event notifications available through integration with their EHR earlier than anticipated. The EHR integration work is complete.

In early May 2018 go-live activities for CMT were put on hold pending CMT system upgrades to support the required elements to insure compliance with privacy laws surrounding substance use treatment.

Network4Health experienced multiple issues with CMT related to lack of a published Upgrade implementation plan, and lack of communication with Network4Health on progress and delays. Network4Health's HIT Director met with DHHS leadership to review concerns and addressed these issues as they related to the state project as a whole. A list of expectations on CMT and specific Network4Health requirements related to communication, planning, and testing was presented to CMT on June 25, 2018. Network4Health has now received response from CMT and is confident in their project plan and CMT's commitment to our success.

Network4Health is currently working with the Catholic Medical Center's Emergency Department staff to schedule rollout and training on both the event notification reports for general use in the Emergency Department and availability of the CMT ED portal to support care coordination in the Emergency Department. Catholic Medical Center is anticipated to be ready for go-live with both their ADT feed and receipt of event notifications from CMT (for use in the Emergency Department) in late August 2018.

Both Elliot Health System and Parkland Medical Center received the CMT User Agreement in Q4 2017. At this time neither organization has moved forward with contract signature. Network4Health leadership continues to meet and review the need to expedite this process. Recent discussions with the Elliot Health System have been positive and we expect contract execution within before September 30, 2018. Despite multiple meetings and communications, Network4Health has received minimal response from Parkland Medical Center regarding their intent to participate in the CMT implementation. Network4Health will continue to attempt to engage Parkland Medical Center on this issue.

In addition to utilizing CMT's event notification functionality, Network4Health has finalized our intent to utilize CMT for Shared Cared Planning across our partner organizations. Network4Health has completed a product comparison of care coordination tools, such as Eccovia ClientTrack and Allscripts CareDirector, and determined that with a majority of our primary care and behavioral health partners already utilizing a care management tool, typically within the constructs of their EHR, there is not sufficient interest or need to add any additional care management tools. In implement the Shared Care Planning tool, Network4Health is focusing its attention on the development of integrated workflows to support sharing of existing care plans and partner collaboration in treatment. If the need for a care management tool is identified through the B1 Integrated Health team's Integration Enhancement Plans, Catholic Medical Center has confirmed an ability to extend their instance of Allscripts Care Director to partner organizations. Kick off of CMT Premanage community will begin with a partner overview July 27, 2018. We expect implementation of our B1 cohort 1&2 organizations to be complete by December 2018.

MAeHC Data Aggregator Service

As indicated in our implementation plan, Network4Health has moved forward in alignment with all NH DSRIP IDNs to both initiate contract negotiations and evaluate implementation requirements with the selected data aggregator service, Massachusetts eHealth Collaborative (MAeHC). The Network4Health HIT team has spent considerable time since October 2017 working with both the NH DSRIP team at NH DHHS and representatives of the MAeHC to clarify the performance measurement reporting requirements to support implementation with MAeHC. Significant issues, such as a cross-IDN policy on the included reporting population, clear definition of the inclusion criteria for patients in different Medicaid programs and the completion criteria for a Comprehensive Core Standardized Assessment were discussed at length and most issues have been resolved to the satisfaction of Network4Health B1 participating partners. As indicated and in-alignment with other IDNs, Catholic Medical Center as the Network4Health administrative lead executed a contract with MAeHC for IDN data aggregator services. Network4Health has created a sub-contract data sharing agreement and Business Associates Agreement for review and signatures with each of our key data partners in order for them to move forward with MAeHC implementation. In April of 2018 Network4Health successfully submitted data to MAeHC from 2 partner organizations. With multiple data sharing agreements now in place we anticipate data submission for the January to July period to represent 11 of our B1 partners and allow for aggregate performance reporting prior to the August 15, 2018 deadline. Network4Health and our data partners continue to work closely with MAeHC to prepare for a speedy implementation and increased reporting capability.

While the Network4Health team continues to evaluate the potential for additional usage of the aggregated data and functionality available from MAeHC, at this time, there are no plans for use of the MAeHC data aggregator service beyond the required DSRIP performance reporting.

Comprehensive Core Standardized Assessment (CCSA) IT Implementation Support

Network4Health will make two options available to partners implementing a CCSA as part of their B1 Integration Enhancement Plan. They may either choose to modify their EHR to support data collection based on screening questions across all required CCSA domains or they may choose to implement PatientLink. PatientLink is a tool that provides organizations the ability to capture and send discrete, structured patient data into the electronic health record and/or produce a PDF formatted document to support our non EHR partners thus reducing the time and resources needed to support manual data entry. Network4Health has executed a contract which allows access to PatientLink for those partners who choose to implement it. Proof of concept has been completed at Catholic Medical Center to demonstrate patient intake forms that would cover the required CCSA domains through PatientLink.

Closed Loop Referral Support

Referrals represent a unique inflection point where the next step in care is driven not only by clinical goals, but also by plan design and the resources available within the provider's own community. To support our partners and patients, Network4Health will support the implementation of a closed loop referral system. We are currently in the process of contracting for a product called Par8O. With Par8o, decision support including network participation, plan design, provider clinical preferences, and appointment availability is visible to referring providers and staff at the point of referral. Through this application, we will be able to monitor and report referrals across Network4Health and provide visibility to our unique community resources.

Network4Health is planning to demonstrate the functionalities of Par8O and the substantial impact it could have for multiple IDN's and the Manchester Health Department to promote increasing its use across the state.

Implementation of Par8O is expected to begin in Q4 of 2018 with an estimated completion date of March, 2019.

Workforce

Network4Health has determined that due to the vast types of support needed by our community that we would be better served by contracting with an IT consulting firm that can support the various needs including EMR Build, project management, implementation support, training plan development and interface development, instead of hiring an internal HIT analyst.

Network4Health has updated and streamlined the HIT project plan (see Attachment_A2.3) to align with our current program needs and timing expectations. The chart below provides a high-level overview with the major HIT project aims:

HIT Project Overview	12/31/17	6/30/18	12/31/18
Aim 1: DIRECT set up and roll out			X
Aim 2: Sending of ADTs for ENS via CMT		X	
Aim 3: Enroll ENS subscribers, train, and transmit notifications via CMT		X	X

HIT Project Overview	12/31/17	6/30/18	12/31/18
Aim 4: Design and Build SCP process and workflow based on available CMT functionality (in alignment with B1 team)		X	X
Aim 5: Comprehensive Core Standardized Assessment rollout: PatientLink Rollout or Partner EHR Modifications		X	X
Aim 6: Train staff on solutions			X
Aim 7: Roll out solutions			X

A2-4. IDN HIT: Evaluation Project Targets

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of participating partner organizations who acquire DIRECT Secure Messaging	17of 18 practices by 12/31/18	9	17	
The number of participating partners who acquire the Event Notification System (ENS)	17 of 18 practices by 12/31/18	1	1	
The number of participating partners who acquire the Shared Care Plan (SCP)	17 of 18practices By 12/31/18	0	0	
The number of participating partner organizations who implement and receive training for DIRECT Secure Messaging	17 of 18 practices by 12/31/18	0	16	
The number of participating partners who implement and receive training for the Event Notification System (ENS)	17 of 18 practices by 3/31/2019	0	0	
The number of participating partners who implement and receive training for the Shared Care Plan (SCP)	12 of 18 practices By 12/31/19	0	0	
The number of participating partners who contribute to DIRECT Secure Messaging	17of 18 practices by 12/31/18	0	16	
The number of participating partners who contribute to Event Notification System (ENS)	14 of 18 practices by 12/31/18	0	0	
The number of participating partners who contribute to a Shared Care Plan (SCP)	10 of 18practices By 12/31/19	0	0	

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of participating partner organization who use DIRECT Secure Messaging	17 of 18 practices by 12/31/19	0	16	
The number of participating partners who use an Event Notification System (ENS)	14 of 18 practices by 12/31/19	0	0	
The number of participating partners who use a Shared Care Plan (SCP)	10 of 18 practices By 12/31/19	0	0	

A2-5. IDN HIT: Workforce Staffing

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

Staff Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
HIT Director	Up to 1	0	1	1	
IT Consultants	Up to 4000 hrs	0	0	Contracted	

A2-6. IDN HIT: Budget

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

The HIT budget is presented below. Modifications have been made based on several factors:

Revenue- All project budgets have been adjusted to reflect the actual receipt or availability of future funding. Previously, our budgets were developed utilizing revenue projections based on the time period for which they could be earned. Revenue for 2018 is being reported in two new columns. The first identifies the actual incentive funding received in May for the July to December 2017 reporting period. It represents a partial payment with the remainder expected soon. The second column, for 2018, projects the receipt of the remaining prior period incentive funding as well as incentive funding anticipated for November. N4H has also added a column for the period of January to June 2021 as we have been informed that our final potential incentive payment would be expected in May or June of 2021.

Expenses- Actual expenses (paid and invoices received) for the period of January to June of 2018 are presented. Anticipated expenses (including those for January to June not yet invoiced) are presented in the column reflecting July to December 2018. Given that final incentive funding is not expected to be

received until May or June of 2021, we have projected expenses in that period as we conclude the waiver projects.

Reported actual expenses continue to be below budget due in part to expense reporting that includes only invoiced and paid expenses.

Transformation Funds	CY 2017 (Yr2) Actuals	CY 2018 (Yr 3) January to June Actual	CY 2018 (Yr3) July to December Projected	CY 2019 (Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) Projected
A2 HIT Revenue (New)	$862,544	$483,025	$1,242,063	$1,380,070	$875,316	$357,796
A2 HIT Revenue (Rollover)		$826,276	$1,022,251	$189,501	$26,106	$2,143
Total Revenue	$862,544	$1,309,301	$2,264,314	$1,569,571	$901,422	$359,939
Event Notification System and Shared Care Plan						
Premanage ED - annual Subscription for CMC, Elliot, Parkland		$19,364	$139,802	$83,181	$85,677	$43,000
Premanage Primary/Community ($0.12 per Medicaid member per month) - Software License		$34,240	$55,760	$90,000	$90,000	$45,000
Premanage PMDP ($50 / provider/yr., ~200 providers) - Software License		$10,000	$10,300	$10,609	$10,927	$10,000
B1 Integration Enhancement Plan Support Funds						
Integrated Care IEP Implementation Support (care planning tool licensing, other HIT tool licensing, implementation fees, HIT Training, HIT consulting, existing tool development or customization costs, etc.			$ 1,025,000	$625,000	$225,000	
Secure Messaging						
Direct secure messaging ($750*30) - Software License			$25,000	$25,000	$25,000	$25,000
Data Aggregator						
Data aggregator implementation		$123,445	$99,800			
Data aggregator Annual Service Fees		$31,125	$31,125	$62,675	$62,675	$62,675
Data Aggregator Customizations, Consulting, Custom Reporting		$ -	$100,000	$100,000	$ -	
Secure Data Storage						
Referrals						
Closed Loop Referral System			$150,000	$100,000	$75,000	
CCSA Implementation						
Patient Link Implementation and Licensing Costs			$150,000	$100,000	$75,000	$50,000
EMR Integration (Technical Assistance Fund)			$55,000	$45,000	$25,000	
Other						
Contingency Fund	$2,170	$532	$49,468	$50,000	$25,000	
Internet Connectivity		$148	$19,852	$12,000	$ -	
HIT Salary	$34,098	$68,196	$163,706	$240,000	$200,000	$120,000
Subtotal	$36,268	$287,050	$2,074,813	$1,543,465	$899,279	$355,675
Variation to Budget (Transfer Funds to Proceeding Year)	$826,276	$1,022,251	$189,501	$26,106	$2,143	$4,264

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

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

B1 Organizations	Type
The Mental Health Center of Greater Manchester	CMHC
Center for Life Management	CMHC
Dartmouth Hitchcock Clinic- Manchester and Bedford	PCP
Catholic Medical Center: Amoskeag Family Practice	PCP
Catholic Medical Center : CMC Behavioral Health	BH/SUD
Catholic Medical Center: Willowbend Family Practice	PCP
Catholic Medical Center: Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	PCP
Catholic Medical Center - Healthcare for the Homeless	FQHC/PCP
Elliot Health System: Doctors Park Pediatrics, Manchester	PCP
Elliot Health System: Partial Hospitalization Program	BH
Families in Transition/New Horizons	Res/SUD
Fusion	SUD
Easter Seals NH (Farnum Center)	SUD/CBSSO
Manchester Community Health Center: Hollis Street	FQHC/PCP/BH
Child Health Services at MCHC	FQHC/PCP/BH
MCHC East Side (Tarrytown Rd)	FQHC/PCP/BH
West Side Neighborhood Clinic	FQHC/PCP/BH
Ancillary HIT Participants	**Type**
Hope for NH Recovery	Recovery/ Peer
Makin It Happen	PREV/PH
City of Manchester Health Department	PH/PREV
Bhutanese Community of NH	CBSSO
Community Crossroads	CBSSO
Granite Pathways (FedCap)	CBSSO
Greater Derry Community Health Services	CBSSO
Life Coping Inc.	CBSSO
Pastoral Care Services	CBSSO
The Moore Center	CBSSO
The Upper Room	CBSSO
Granite United Way	CBSSO

A2-8. IDN HIT. Data Agreement

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

Organization	Data Sharing Agreement signed
The Mental Health Center of Greater Manchester	Y
Center for Life Management	Y
Manchester Community Health Center (4 practices)	Pending**
Dartmouth Hitchcock Clinic- Manchester and Bedford	Y
Catholic Medical Center	Y
Catholic Medical Center - Primary Care (4 practices)	Y
Catholic Medical Center - Healthcare for the Homeless	Y
Elliot Health System	Pending
Families in Transition	Y
Fusion	Y
Easter Seals NH (Farnum Center)	No*
Parkland Medical Center	Pending

*Network4Health continues to meet with leadership from the Farnum Center to identify opportunities to support enhanced integration efforts at their agency. We hope to include them in a cohort 3 funding review. The data sharing agreement will be requested upon IEP approval

**Network4Health Continues to support MCHC with legal guidance and assistance and expect signature before July 31, 2018 to support the upcoming reporting period

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				

Task Name	Duration days	Start	Finish	Predecessors	% Complete
HIT Implementation Plan	1488	01/02/17	01/29/21		21%
State Level HIT Planning	728	01/02/17	12/31/18		100%
Participate in Statewide HIT Planning	149	01/02/17	05/31/17		100%
Receive Statewide HIT Report (informs IDN 4 Implementation Plan)	395	06/01/17	07/01/18		100%
Create IDN 4 HIT Implementation Plan	179	01/01/18	06/29/18		100%
Network 4 Health/IDN 4 HIT Implementation Plan	851	09/01/17	12/31/19		6%
Event Notification and Shared Care Planning (CMT)	1	09/20/17	09/21/17		14%
Sign IDN Support Contract w/ CMT (Network 4 Health/CMC Admin lead)	1	09/20/17	09/21/17		100%
CMT Master Service Agreement and PreManage Service Orders	345	09/20/17	08/31/18		1%
CMC Signed Agreement	0	09/20/17	09/20/17		100%
Elliot Signed Agreement	270	12/04/17	08/31/18		
Parkland Signed Agreement	270	12/04/17	08/31/18		
ADT Feed Implementation to NH CMT PreManage Platform	466	09/21/17	12/31/18		46%
CMC ADT feed Implementation, Testing and Go-Live	344	09/21/17	08/31/18	10	90%
Elliot ADT feed Implementation, Testing and Go-Live	273	04/02/18	12/31/18	11	
Parkland ADT feed Implementation, Testing and Go-Live	273	04/02/18	12/31/18	12	
Emergency Department Event Notifications (CMT PreManage EDIE)	154	01/29/18	07/02/18		
CMC Emergency Department	63	01/29/18	04/02/18		
Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	11	01/29/18	02/09/18	14FS -45d	
Implementation and Testing	32	02/12/18	03/16/18	19	
Emergency Department Training	29	08/01/18	08/30/18	20	
Go-Live	1	08/30/18	08/31/18	21	
Elliot Emergency Department	245	04/30/18	12/31/18		
Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	124	04/30/18	09/01/18	15FS -45d	
Implementation and Testing	61	10/01/18	12/01/18	24	
Emergency Department Training	29	12/01/18	12/30/18	25	
Go-Live	1	12/30/18	12/31/18	26	
Parkland Emergency Department	245	04/30/18	12/31/18		
Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	124	04/30/18	09/01/18	16FS -45d	
Implementation and Testing	61	10/01/18	12/01/18	29	
Emergency Department Training	29	12/01/18	12/30/18	30	
Go-Live	1	12/30/18	12/31/18	31	
Primary Care and BH Providers Event Notification (PreManage Community)	272	04/02/18	12/30/18		
Cohort 1 Participants - B1 Integrated Care Project	272	04/02/18	12/30/18		
Sign CMT User Agreements	35	07/27/18	08/31/18	14	

Task Name	Duration days	Start	Finish	Predecessors	% Complete
Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	65	07/27/18	09/30/18	35FS -15d	
Shared Cared Planning Implementation	212	06/01/18	12/30/18		
Workflow	39	06/25/18	08/03/18	35	
Training	90	10/01/18	12/30/18	38	
Go Live	62	10/29/18	12/30/18	39	
Cohort 2 Participants - B1 Integrated Care Project	272	04/02/18	12/30/18		
Sign CMT User Agreements	35	07/27/18	08/31/18		
Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	65	07/27/18	09/30/18	42	
Shared Cared Planning Implementation	212	06/01/18	12/30/18		
Workflow	39	06/25/18	08/03/18	42	
Training	90	10/01/18	12/30/18	45	
Go Live	62	10/29/18	12/30/18	46	
Cohort3 Participants - B1 Integrated Care Project	362	04/02/18	03/30/19		
Sign CMT User Agreements	30	09/01/18	10/01/18		
Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	246	07/27/18	03/30/19	42	
Shared Cared Planning Implementation	302	06/01/18	03/30/19		
Workflow	158	06/25/18	11/30/18	42	
Training	43	02/15/19	03/30/19	45	
Go Live	62	10/29/18	12/30/18	46	
Comprehensive Core Standardized Assessment (PatientLink or EHR Build)	501	12/11/17	04/26/19		
PatientLink	501	12/11/17	04/26/19		
Proof of Concept (N4H and PatientLink - CMC existing contract)	216	12/11/17	07/15/18		
Sign IDN Support Contract w/ PatientLink (Network 4 Health/CMC Admin lead)	160	02/05/18	07/15/18		
B1 Cohort 1	326	02/05/18	12/28/18		
Identify Cohort 1 Integrated Care Patientlink Participants	116	02/05/18	06/01/18		
B1 Cohort1 - Sign Participant Agreements w/ PatientLink (Partner Orgs)	178	03/05/18	08/30/18	51	
Site Level Implementations: Requirements, Build, Testing, Training	129	06/25/18	11/01/18	54	
Go-Live(s) and Data Collection (Modifications and Lessons Learned)	91	09/30/18	12/30/18	55	
B1 Cohort 2	326	02/05/18	12/28/18		
Identify Cohort 2 Integrated Care Patientlink Participants	116	02/05/18	06/01/18		
B1 Cohort2 - Sign Participant Agreements w/ PatientLink (Partner Orgs)	178	03/05/18	08/30/18	58	
Site Level Implementations: Requirements, Build, Testing, Training	129	06/25/18	11/01/18	59	
Go-Live(s) and Data Collection (Modifications and Lessons Learned)	91	09/30/18	12/30/18	60	
B1 Cohort 3	418	02/05/18	03/30/19		
Identify Cohort 3 Integrated Care Patientlink Participants	122	08/30/18	12/30/18		
B1 Cohort2 - Sign Participant Agreements w/ PatientLink (Partner Orgs)	178	03/05/18	08/30/18	58	

Task Name	Duration days	Start	Finish	Predecessors	% Complete
Site Level Implementations: Requirements, Build, Testing, Training	212	08/30/18	03/30/19	59	
Go-Live(s) and Data Collection (Modifications and Lessons Learned)	105	01/15/19	04/30/19	60	
Data Aggregator Services (MAeHC)	454	09/01/17	11/29/18		15%
Identify capable vendors	0	09/01/17	09/01/17		100%
Sign IDN Support Agreement	83	11/03/17	01/25/18	63FS +45d	95%
CMC Denominator Submission	32	01/26/18	02/27/18	64	
Sign Data Sharing Sub-Contracts with Network4Health Partners (begin implementation as contracts are signed)	247	01/26/18	09/30/18	64	
Implementation, Testing, Go-Live (as contracts are signed)	265	03/09/18	11/29/18	66SS +30d	
Closed Loop Referral Tool (Par8o)	457	01/01/18	04/03/19		
Validate vendor selection	58	01/01/18	02/28/18		
Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	245	03/01/18	11/01/18	69	
Identify Partner Organizations for Implementation	184	03/01/18	09/01/18	70SS	
Configuration, Workflow and Implementation	111	09/06/18	12/26/18	72	
Training	55	12/27/18	02/20/19	73	
Go-Live(s)	41	02/21/19	04/03/19	74	
Direct Secure Messaging (MedAllies)	340	01/01/18	12/07/18		
Validate vendor selection	81	01/01/18	03/23/18		
Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	39	03/26/18	05/04/18	77	
Identify Partner Organizations for Implementation (B1 Project - Cohort 2)	39	05/07/18	06/15/18	78	
Sign Participant Agreements (Partner Orgs)	4	06/18/18	06/22/18	79	
Configuration, Workflow and Implementation	127	06/25/18	10/30/18	80	
Training	71	08/20/18	10/30/18	81	
Go-Live(s)	15	10/15/18	10/30/18	82	

Project B1: Integrated Healthcare

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

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

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

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

The Coordinated Care Practice must include:

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

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

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

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

Progress Narrative

During this reporting period, Network4Health's B1 Integrated Healthcare project participants made significant progress towards coordinated and integrated care designation. Perhaps the biggest challenge is related to culture change, to a more cooperative way of thinking between clinical disciplines, e.g. medical and mental healthcare, and between competitive organizations. One valuable change management tool has been the Site Self-Assessment (SSA) that is being used by each B1 partner across all Integrated Delivery Networks (IDN) statewide. While the SSA is somewhat subjective, it helps organizations to collectively review where they are on the integration continuum, and gain a better understanding of the components of integration, fostering internal discussion. Before the SSA was administered to most partners for the 2nd time, we had New Hampshire Citizen's Health Initiative team (NH CHI), the vendor responsible for the online SSA administration and reporting, present to the B1 workgroup. Not only did CHI talk about the survey process, but also about the purpose for the SSA, which further helped socialize the concepts of integrated care, and prompted good discussion. Feedback from that workgroup was that the presentation and discussion were "interesting and very helpful."

We anticipate the results of the second SSA, may show little to no movement along the continuum, or perhaps a slight movement backwards as they gain a more critical eye around what defines integrated healthcare delivery within their practice. Again, this will be valued as a culture change and learning opportunity.

The integration enhancement project (IEP) plans, submitted by all but two B1 partners this reporting period, required each organization to include their plans and timelines to meet the following components of coordinated care practice:

- Comprehensive Core Standardized Assessment with required domains;
- Multi-disciplinary Core Teams;
- Information sharing: care plans, treatment plans, case conferences
- Standardized workflows and protocols

Likewise, the two partners working toward the integrated care practice designation, Manchester Community Health Center and Healthcare for the Homeless, included plans and timelines to address the above coordinated care requirements, as well as the following:

- Medication-assisted treatment (MAT)
- Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either
- Enhanced use of technology

Network4Health completed the development and review process for Integration Enhancement Plan (IEP) funding proposals for four cohort 1 and five cohort 2 participants. Funding proposals were released, and meetings were scheduled to review milestones and funding details with each organization. IEP funding was supported by the B1, A1 and A2 projects. Due to potential funding level uncertainty, it was agreed by the Steering Committee that each funding proposal would include currently available funds for 2018 and proposed 2018 funds that are dependent on continued funding availability. The development and review process for the two Cohort 3 participants, Easterseals - Farnum Center and Elliott Health System-Partial Hospitalization Program is underway.

Hiring

Network4Health's new Integrated Healthcare Clinical Director, [redacted], MS, RN, CCM, began her role on January 2, 2018 to provide practices with an experienced integrated healthcare resource for our region. Network4Health also completed their contract with the University of New Hampshire (UNH) in late January for support from their New Hampshire Citizen's Health Initiative team (NH CHI) to provide practice level facilitation to our project participants. UNH/NH CHI is also contracted to manage the continued collection of the Site Self-Assessment (SSA) Evaluation Tool from the Maine Health Access Foundation Integration Initiative for all participating practices. The SSA tool will continue to provide a standardized assessment of a practice's progress along the continuum of integrated care.

Participant Implementation Process: General

Partner engagement can be a challenge in the ever-changing healthcare landscape, with many initiatives and pressures impacting our partners. Network4Health appreciates this and all staff, including leadership and the Steering Committee members are instrumental in engaging members and encouraging collaboration through the IDN and statewide. On occasion we have elicited advice and

support from the NH DHHS DSRIP Team regarding partner engagement and support in developing potential solutions.

Participant Implementation Process: Integration Enhancement Plans (IEPs) Cohort 1

As previously reported, the practices listed below agreed to participate in Network4Health's Cohort 1 Integration Enhancement Plans (IEPs).

No.	Organization Type	Organization / Practice Name
1	Primary Care	**Catholic Medical Center - Behavioral Health Services**
2	Primary Care	**Catholic Medical Center - Family Health & Wellness Center at Bedford**
3	Primary Care	**Catholic Medical Center - Willowbend Family Practice**
4	Primary Care	**Catholic Medical Center - Amoskeag Family Practice**
5	Primary Care	**Catholic Medical Center - Hooksett Internal Medicine**
6	Primary Care	**Dartmouth-Hitchcock Manchester and Bedford Adult Practice**
7	Primary Care	**Dartmouth-Hitchcock Bedford/Manchester Pediatric Practice**
8	Primary Care	**Elliot Health System - Elliot Family Medicine at Hooksett**
9	Primary Care	**Elliot Health System - Elliot Pediatrics and Primary Care at Riverside**
10	Primary Care and Behavioral Health	**Manchester Community Health Center (FQHC)**
11	Behavioral Health	**Mental Health Center of Greater Manchester (CMHC)**

Beginning in January 2018, the Network4Health Integrated Healthcare team, including Network4Health's Integrated Healthcare Clinical Director, HIT Director, Program Manager and Practice Facilitators from NH CHI, met with representatives from each Cohort 1 organization to further review the detailed requirements of the B1 Integrated Healthcare project and discuss feasible and sustainable approaches to behavioral health and primary care integration for their organization. The team met regularly with most groups throughout the IEP development process to answer questions and provide feedback. Cohort 1 IEPs were submitted to Network4Health for funding review on February 26, 2018.

A team of Network4Health staff including the Executive Director, Integrated Healthcare Clinical Director, HIT Director, Workforce Development Director and the Integrated Healthcare Program Manager reviewed and scored the proposals based on pre-established criteria. NH CHI team members also reviewed and provided input on each proposal. Funding decisions were based on the scope of the work proposed and availability of budgeted funds. The initial funding review process took longer than expected given the significant scope of the proposed projects to meet both the B1 project requirements

and align with the strategic plans of participating organizations. In addition, Network4Health further delayed releasing funding proposals to IEP participants due to uncertainty regarding the available funding levels for the NH DSRIP program. Funding proposals were released to four of our five cohort 1 participants approximately one month later than expected, in mid-April 2018, after review with the Network4Health Integrated Healthcare Project Advisory Board and Network4Health Steering Committee. Network4Health requested continued discussion with Elliot Health System to further define their IEP to encompass all NH DSRIP integration requirements and a re-submission of their IEP for review during cohort 2 funding.

Implementation planning sessions began in April 2018 with the four funded cohort 1 IEP organizations(Catholic Medical Center, Dartmouth-Hitchcock, Manchester Community Health Center and The Mental Health Center of Greater Manchester). The creation, negotiation and dissemination of approved Statements of Work (SOWs) to provide access to IEP funding has taken significantly more time than anticipated. SOWs are expected to be fully executed by the end of July. All organizations moved forward with project planning between April and June. Some organizations were also able to make significant progress on workflow development, job descriptions and in some cases interviewing and hiring new staff. The NH CHI practice facilitation team began working with both the Dartmouth-Hitchcock adult and pediatric teams to help further guide their integration implementation plan.

Below is an overview of each organization's Integration Enhancement Plan:

- **Catholic Medical Center**
    - Inclusion of 3 primary care practice sites and CMC behavioral health services department included in Cohort 1. A pilot site will be selected to initiate Screening, Brief Intervention and Referral to Treatment (SBIRT) and Comprehensive Core Standardized Assessment (CCSA), with further rollout to other practices after initial trial period.
    - Incremental plan to expand internal referral and collaboration processes between primary care and CMC behavioral health services department. Introduction of up to 3 Behavioral Health Patient Navigators and 1 Licensed Mental Health Clinician to better support social determinants of health needs, substance misuse/abuse needs and mental health needs.
    - Initial focus on process expansion and coordination support for Medicaid patients
    - Movement toward fully integrated model with embedded behavioral health services
    - Implementation of SBIRT
    - Implementation of PatientLink scanners and software to support CCSA implementation and creation of standardized protocols for positive screenings.
    - Willingness to participate in Shared Care Planning for high complexity patients using the Collective Medical Technologies (CMT) platform supported by Network4Health
- **Dartmouth-Hitchcock**
    - Introduce integrated onsite primary care/ behavioral health teams at adult and pediatric practice sites. Multi-disciplinary team will be expanded to include up to 3 Licensed Mental Health Clinicians and 1 Family Support Specialist. Psychiatric support will either be coordinated through the Dartmouth-Hitchcock system or through a consulting relationship.
    - Implementation of Medication Assisted Treatment (MAT) with up to 5 waivered providers. The implementation will include collaboration with one or more external

service providers to support initial induction and stabilization of MAT patients. Patients could then be transferred back to the Dartmouth-Hitchcock primary care team for continued treatment and support upon stabilization.
    - Adding screenings for any missing domains for the Comprehensive Core Standardized Assessment (CCSA), EMR modifications and standardized protocols for positive screenings. This is being done in coordination with other Dartmouth-Hitchcock primary care sites across IDNs.
    - Willingness to participate in Shared Care Planning for high complexity patients using the Collective Medical Technologies (CMT) platform supported by Network4Health
- **Manchester Community Health Center**
    - Expansion of current integrated primary care/ behavioral health care team model using Behavioral Health Consultants, Case Managers and Community Health Workers to all 4 practice sites. This also requires significant physical re-configuration of practice space to allow all multi-disciplinary teams to be co-located in pods. Key new staff to be supported by IEP funding in second half of 2018: 1 Behavioral Health Consultant, 3 Community Health Workers, 2 Case Managers
    - Implementation of IMPACT or other evidence-based model for treating mild to moderate depression
    - Implementation of the Survey of Well-being of Young Children (SWYC) evidence-based development screenings for pediatric patients
    - Adding screenings for any missing domains for the Comprehensive Core Standardized Assessment (CCSA), EMR modifications and standardized protocols for positive screenings.
    - Expansion of multi-disciplinary core team to include psychiatry. Daily huddles are currently in place for their existing multi-disciplinary teams.
    - Willingness to participate in Shared Care Planning for high complexity patients using the Collective Medical Technologies (CMT) platform supported by Network4Health
- **The Mental Health Center of Greater Manchester**
    - Creation of Intensive Treatment Team (ITT) to support the identification, assessment and transition of high-risk individuals as they progress through a continuum of acute care services. The selected model is based on successes of current programs on the west coast, the ITT at Health Share of Oregon (http://www.healthshareoregon.org/transforming-health-together/care-innovations/behavioral-health-care/itt) and Washington County with Lifeworks NW (https://www.lifeworksnw.org). Key new staff positions to be supported by IEP funding in second half of 2018: ITT Coordinator, 4 ITT Case Managers, ITT Peer Specialist and a part-time APRN.
    - Expansion of integrated behavioral health services to support referrals and coordination with Network4Health primary care provider organizations
    - Collaboration with emergency departments to support referrals and coordination with Network4Health primary care provider organizations
    - Adding screenings for any missing domains for the Comprehensive Core Standardized Assessment (CCSA), EMR modifications and standardized protocols for positive screenings.

- Expansion of multi-disciplinary core team to further engage with primary care for high complexity patients.
- Willingness to participate in Shared Care Planning for high complexity patients using the Collective Medical Technologies (CMT) platform supported by Network4Health. Daily multi-disciplinary huddles are currently in place for complex behavioral health patients with Elliot Hospital Emergency Department through the existing Shared Response Team.

Participant Implementation Process: Integration Enhancement Plans (IEPs) Cohort 2

Beginning in March 2018, the Network4Health Integrated Healthcare team, including Network4Health's Integrated Healthcare Clinical Director, HIT Director and Program Manager met with representatives from each of the Cohort 2 organizations who agreed to participate in the development of an Integration Enhancement Plan. Network4Health's newest IDN partner, Fusion Health Services joined as a new B1 Integrated Healthcare participant. Fusion is a newly formed primary care and specialty substance use disorder practice. In addition to their own patients, they also partner with other New Hampshire organizations to provide MAT services. The Fusion team completed the first step in the Network4Health IEP process by submitting a Site Self-Assessment.

As a lesson learned based on feedback received from Cohort 1 participants, the Network4Health team kept the IEP development meetings smaller and informal. The team met more frequently with each group to support their individual IEP development process. Cohort 2 IEPs were submitted to Network4Health for funding review on June 8, 2018. The same Network4Health review process was initiated as was referenced for the cohort 1 participants. IEP funding proposals are targeted for dissemination to cohort 2 participants in July 2018, with contracting completion to immediately follow and implementation targeted to begin in late August or September 2018.

No.	Organization Type	Cohort 2 Organization / Practice Name
1	CMHC	**Center for Life Management**
2	Primary Care	**Catholic Medical Center – Healthcare for the Homeless**
3	Primary Care	**Elliot Health System**
4	SUD	**Families in Transition – New Horizons, Willows Treatment and Recovery Center**
5	Primary Care/Specialty SUD	**Fusion Health Services**

Participant Implementation Process: Integration Enhancement Plans (IEPs) Cohort 3

The final two practices included in Network4Health list of B1 participants are Easterseals NH's Farnum Center and Elliot Health System's new Partial Hospitalization Program (PHP). Network4Health made multiple attempts through meetings and email communication to include Easterseals NH's Farnum Center in the Cohort 2 IEP funding process. Ultimately, the cohort 2 timing was not feasible for their

team. Network4Health continues to meet with leadership from the Farnum Center to identify opportunities to support enhanced integration efforts at their agency. We hope to include them in a cohort 3 funding review.

Elliot Health System's PHP program is being stood up with support from the Network4Health D3 project. To date, their efforts have been focused on initiating this important new program, but always with an emphasis on integration. IEP development meetings will begin with the Director of the PHP program in July 2018 to identify how the B1 Integrated Healthcare project can support the new program in meeting all of the specific DSRIP coordinated care designation requirements.

Core Deliverables, Workflows and Protocol Support

As projected in our January report, our bi-monthly Integrated Care Workgroup completed the Network4Health CCSA recommendations in January 2018. As a follow-up to the evidence based screening questions, Network4Health's Integrated Healthcare Clinical Director released recommendations for follow-up protocols to a positive screening across all CCSA domains for our B1 IEP practices. All B1 IEP practices will submit their organization's CCSA screening questions and positive screening protocol to Network4Health as a milestone of their IEP implementation.

In addition to the CCSA work, Network4Health provided our B1 IEP organizations with best practice recommendations for the development of multi-disciplinary teams and the creation of closed loop referral workflows to support their IEP implementation, as well as the SBIRT and MAT protocols created by NH Community Health Institute (NH's Public Health Institute) in partnership with NH DHHS. Network4Health believes it's important to align recommendations with other NH initiatives as a means to standardized best practices across the region.

Due to delays in the availability of privacy modifications and sensitive information and consent policies for the Collective Medical Technologies (CMT) PreManage tool (being used across most IDN's for Shared Care Planning), Network4Health's Shared Care Planning work has also been delayed. The Network4Health team chose to pause any further Shared Care Planning process work until the release of the system updates. CMT recently made the necessary revisions which Network4Health is currently reviewing with the support of outside counsel. The Shared Care Plan process development milestones have been updated for completion in fall 2018 in the attached project plan.

Trainings

In addition to the trainings detailed in sections B1-8c and B1-8d below, Network4Health supported partners evolution with the following activities:

- The May 25, 2018 Integrated Care Workgroup focused on project management fundamentals for organizations kicking-off integration enhancement projects. The Network4Health Program Manager provided teams with a Project Kick-Off presentation template that reviewed key components that must be developed to support a well- organized project. The presentation was provided to all B1 participants to modify for use in communicating their projects within their organization.

- Network4Health's Integrated Care Clinical Director met with representatives from NH Healthy Families to discuss opportunities for collaboration with Network4Health. In addition to including NH Healthy Families in our bi-monthly Integrated Care workgroup, their Clinical Provider Trainer has provided a lengthy list of trainings they offer at no cost to Network4Health Integrated Healthcare project participants and are able to deliver at our partner sites. In particular, Network4Health will be asking participating practices to schedule their Cultural Competence offering and new SBIRT training. This partnership will allow Network4Health to provide productivity offsets to assure that organizations are able allow staff to attend these types of trainings.
- Network4Health's Integrated Healthcare Clinical Director attended the Manchester, NH Veterans Summit addressing mental healthcare for Veterans, where partners such as the Mental Health Center of Greater Manchester also attended. These resources will be shared with partners at the B1 workgroup and during individual meetings.

Updated work plans for our Coordinated Care partners and Integrated Care partners are included as Attachment_B1.2a and Attachment_B1.2b, respectively.

B1-3. IDN Integrated Healthcare: Evaluation Project Targets

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

Progress has been made to address HIT infrastructure gaps identified during the current state assessment and ongoing meetings between the HIT Director and Network4Health partners to find potential solutions at the organizational levels. The Network4Health All-Partners meetings, the A2 & B1 Advisory Committee meetings, and the B1 Integrated Care workgroup meetings have each been used to provide and reinforce information around Health Information Technology (HIT) requirements, performance measures/reporting expectations, and enabling technologies. (Please reference A2-3 for greater detail)

There has been a delay in implementation of event notification and shared care planning related to vendor issues with Collective Medical Technologies (CMT). Other barriers encountered and our actions include the following:

Barrier	Action
Delay in execution of data sharing agreement related to resolution of data privacy issues, stakeholder buy-in, limited stakeholder capacity (resources/infrastructure)	• Data privacy issues: Network4Health engaged in DHHS sponsored learning opportunities and hired outside legal counsel to address the concerns of the various constituents • Stakeholder buy-in: Network4Health Executive Director, Steering Committee members, and the Integrated Healthcare director and program manager held numerous meetings with various stakeholders at a large primary care partner, as well as a large regional SUD provider. Staff also elicited advice and support from lead administrator CMC HIT leadership • Limited stakeholder capacity (resources/infrastructure): The N4H team has problem solved with partners to develop

	solutions to mitigate their individual issues. For example, one partner organization did not have staff or IT infrastructure to address their HIT needs and N4H HIT director has worked with them to provide IT consultants to support them through HIT implementation. Three other partners had gaps in their project management capabilities; drawing on the strong project management skills of the program manager, we've worked closely with them, coaching, providing project management guidance and tools to move the project forward.

The following modifications were made to the Network4Health B1-3 and A2-4 Evaluation Project Targets tables to align with modifications to the B1 and A2 Key Organizational and Provider Participants as discussed with the NH DHHS DSRIP team.

- Targets have been updated to reflect the total number of practices to be 18
- The Target date for "The number of participating partners who implement and receive training for the Event Notification System (ENS)" has been moved out to 3/31/19 (formerly 12/31/18) due to issues documented above regarding delays in our ability to implement the Collective Medical Technologies(CMT) PreManage tool with our primary care and behavioral health partners.
- The target for performance measure "The number of participating partners who implement and receive training for the Shared Care Plan (SCP)" and "The number of participating partners who use a Shared Care Plan (SCP)" has been reduced to 10 due to the significant pushback from partner agencies around the consent requirements to utilize CMT for Shared Care Planning.
- The 12/31/17 "Progress Towards Target" for the Performance Measure: "The number of participating partners who contribute to Event Notification System (ENS)" has been modified from 1 to 0. The 1 organization that was reported in the January 2018 Semi-Annual Report reflected Catholic Medical Center's Emergency Department and Inpatient units implementation of contributing Admit, Discharge and Transfer (ADT) records to CMT. Catholic Medical Center's Emergency Department and Inpatient units are indeed live with sending their ADT records to CMT, however, it was clarified that below measures should reflect only the progress of B1 Key Organizational and Provider Participants. Due to the outstanding issues with CMT, to date no primary care or behavioral health partners have contributed to the Event Notification System (ENS).
- In addition, the target for the Performance Measure: "The number of participating partners who contribute to Event Notification System (ENS)" has been modified from 17 to 14 due to a lack of interest by some primary care and behavioral health practices to go live on Event Notification without all hospitals contributing ADT records to CMT.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of participating partners who acquire DIRECT Secure Messaging	17 of 18 practices by 12/31/18	9	17	

Performance Measure Name	Target	Progress Toward Target		
The number of participating partners who acquire the Event Notification System (ENS)	17 of 18 practices by 12/31/18	1	1	
The number of participating partners who acquire the Shared Care Plan (SCP)	17 of 18 practices By 12/31/18	0	0	
The number of participating partners who implement and receive training for DIRECT Secure Messaging	17 of 18 practices by 12/31/18	0	16	
The number of participating partners who implement and receive training for the Event Notification System (ENS)	17 of 18 practices by 3/31/19	0	0	
The number of participating partners who implement and receive training for the Shared Care Plan (SCP)	10 of 18 practices By 12/31/19	0	0	
The number of participating partners who contribute to DIRECT Secure Messaging	17of 18 practices by 12/31/18	0	16	
The number of participating partners who contribute to Event Notification System (ENS)	14 of 18 practices by 12/31/18	0	0	
The number of participating partners who contribute to a Shared Care Plan (SCP)	10 of 18 practices By 12/31/19	0	0	
The number of participating partners who use DIRECT Secure Messaging	17 of 18 practices by 12/31/19	0	16	
The number of participating partners who use an Event Notification System (ENS)	14 of 18 practices by 12/31/19	0	0	
The number of participating partners who use a Shared Care Plan (SCP)	10 of 18 practices By 12/31/19	0	0	

B1-4. IDN Integrated Healthcare: Workforce Staffing

From Project A1: Workforce Capacity Development Implementation Plan, provide the current number of full-time equivalent (FTE) staff specifically related to this project using the format below.

The Network4Health B1 team includes an Innovation Consultant/Practice Facilitator, which is a contract position with UNH Citizen's Health Initiative. This position works under the direction of the Integrated Care Clinical Director and program manager, and directly with Netwrok4Heatlh partners to support implementation of their integration enhancement projects.

Initially, Network4Health anticipated that the B1 project would hire Community Health Workers (CHWs) directly. However, through strategic planning with Network4Health partners and guidance from the

Network4Health Steering Committee, the decision was made that individual organizations would hire CHWs, funded by Network4Health through approved Integration Enhancement Plans. Encouraging partners to include Patient Navigator/CHW type roles as part of their multi-disciplinary team helps an organization to see the "value add" of CHWs in addressing social determinants of health and improving outcomes. The downstream effect of improved patient and provider satisfaction and potential reduced costs, in turn, should help with sustainability for such positions by partner organizations beyond the waiver period.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Clinical Director	Recruiting up to 1	0	1	1	
Innovation Consultant/Practice Facilitator	Recruiting up to 2	0	0	1	

B1-5. IDN Integrated Healthcare: Budget

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

The Integrated Healthcare budget is presented below. Modifications have been made based on several factors:

Revenue- All project budgets have been adjusted to reflect the actual receipt or availability of future funding. Previously, our budgets were developed utilizing revenue projections based on the time period for which they could be earned. Revenue for 2018 is being reported in two new columns. The first identifies the actual incentive funding received in May for the July to December 2017 reporting period. It represents a partial payment with the remainder expected soon. The second column, for 2018, projects the receipt of the remaining prior period incentive funding as well as incentive funding anticipated for November. N4H has also added a column for the period of January to June 2021 as we have been informed that our final potential incentive payment would be expected in May or June of 2021.

Expenses- Actual expenses (paid and invoices received) for the period of January to June of 2018 are presented. Anticipated expenses (including those for January to June not yet invoiced) are presented in the column reflecting July to December 2018. Given that final incentive funding is not expected to be received until May or June of 2021, we have projected expenses in that period as we conclude the waiver projects.

Reported actual expenses continue to be below budget due in part to expense reporting that includes only invoiced and paid expenses. Significant funding has been committed to the B1 Integrated Healthcare "Integration Enhancement Plans" that have been negotiated with network partners and plan execution will begin in July. The expense for integration coaching has been adjusted to reflect an increased role of the Integrated Healthcare Director and Program Manager in practice facilitation. Savings have been shifted to funds available for implementation of organization level integration enhancement plans.

TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual	CY 2018 (Yr3) January to June Actual	CY 2018 (Yr 3) July to December Projected	CY 2019 (Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) Projected
B1: Integrated Healthcare Revenue (New)	$ 1,035,053	$ 579,630	$ 1,490,477	$ 2,760,141	$ 3,871,864	$ 2,146,776
B1: Integrated Healthcare Revenue (Rollover)		$ 1,032,253	$ 1,544,616	$ 25	$ 51	$ 42
Total Revenue	$ 1,035,053	$ 1,611,883	$ 3,035,093	$ 2,760,166	$ 3,871,915	$ 2,146,818
Salaries and benefits- Integrated Healthcare Clinical Director (1.0 fte)		$ 35,779	$ 123,746	$ 163,635	$ 167,869	$ 86,452
Technology (Laptops, phones, software)		$ 593	$ 3,407	$ 4,000	$ 4,000	$ 2,000
UNH Institute on Health Policy and Practice/Citizen's Health Initiative Baseline and Follow-up Assessments.	$ 2,800	$ 2,800	$ 3,955	$ 3,744	$ 5,606	
UNH IHPP/CHI Integration Enhancement Project plan development.		$ 25,795	$ 15,237			
UNH Law IHPP/CHI Integration coaching.		$ -	$ 291,923	$ 159,716	$ 131,118	
Practice level Integrated Healthcare Enhancement Project plan funding.		$ -	$ 2,592,200	$ 2,422,120	$ 3,556,380	$ 2,054,900
Occupancy		$ 2,300	$ 4,600	$ 6,900	$ 6,900	$ 3,450
Subtotal	$ 2,800	$ 67,267	$ 3,035,068	$ 2,760,115	$ 3,871,873	$ 2,146,802
Variation to Budget (Transfer Funds to Subsequent Year)	$ 1,032,253	$ 1,544,616	$ 25	$ 51	$ 42	$ 16

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

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

Organization/Provider	Agreement Executed (Y/N)
Catholic Medical Center • Amoskeag Family Practice • CMC Behavioral Health • Willowbend Family Practice • Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford) • Healthcare for the Homeless	Y
Center for Life Management	Y
Dartmouth-Hitchcock Bedford/Manchester Adult	Y
Dartmouth-Hitchcock Bedford/Manchester Pediatric	Y
Easterseals NH/ Farnum Center	Y
Elliot Health System • Doctors Park Pediatrics, Manchester • Partial Hospitalization Program	Y
Families in Transition New Horizons (FIT-NH) / Family Willows Treatment Center	Y
Fusion Health Services, LLC*	Y
Manchester Community Health Center • Manchester Community Health Center – Hollis Street Practice • Child Health Services at MCHC • MCHC East Side – Tarrytown Road Practice • West Side Neighborhood Health Center	Y
Mental Health Center of Greater Manchester	Y

*Fusion Health Services, Network4Health's newest partner organization, is a primary care/substance use disorder & Medication Assisted Treatment (MAT) provider practice that became a Network4Health partner in April. Fusion's Integrated Enhancement Plan included plans to work with other primary care sites to improve access to MAT in the region by taking referrals from other primary care providers to provide MAT induction, once stabilized, the patient would be referred back to his primary care provider for MAT management.

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

If all IDN Governance sign-off's were YES in a prior submission and there are no changes, then a resubmission of this section is not required. If any sign-offs were NO or Governance Leadership has changed, then a full resubmission of this information is required with the signatures noted as received.

There are no changes to this section. Network4Health indicated all governance sign-offs as part of the July 2017 submission.

Name	Title	Organization	Sign Off Received (Y/N)

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

Network4Health launched a bi-weekly Comprehensive Core Standardized Assessment (CCSA) Workgroup in October 2017, this workgroup has evolved into a forum for B1 partners to educate, share best practices/lessons learned and develop other Network4Health recommendations, e.g., protocol development to meet waiver requirements. Foundational to successful system change is sharing common definitions of terms, this has been an issue addressed with our partners through the B1 workgroup, as well as sharing evidence-based resources such as the Agency for Healthcare Research and Quality (AHRQ) integrated care site, https://integrationacademy.ahrq.gov/ , and AHRQ's integrated care playbook and Lexicon, (https://integrationacademy.ahrq.gov/products/playbook/about-playbook), (https://integrationacademy.ahrq.gov/products/lexicon).

One of the best outcomes of the B1 workgroup is the partner networking and relationship building, and the value it brings to the partners, as evidenced by the strong attendance, and broad representation of our partners. Noteworthy is that NH's two managed care organizations (MCOs), NH Healthy Families and Wellsense, have become active participants. Both MCOs presented their care coordination services and engaged in active discussion with our partners on how to better collaborate. Some partners arranged for follow up meetings with the MCOs to improve their level of care coordination and shared care planning. Network4Health encourages providers to include MCO care coordinators as part of their multi-disciplinary teams, and have them at the table as joint workflows and protocols are developed.

- The B1 workgroup includes participants from the following Network4Health Integrated Healthcare Partners:
    - Catholic Medical Center

- Center for Life Management
- Child & Family Services
- Dartmouth Hitchcock, Manchester & Bedford
- Elliot Health System, Behavioral Health Services
- Families in Transition
- Fusion Health Services, LLC
- Healthcare for the Homeless
- Manchester Community Health Center
- Mental Health Center of Greater Manchester
- New Hampshire Healthy Families MCO
- Wellsense MCO

B1-8a

CCSA: Partners were provided with the Network4Health recommended CCSA process and care plan for positive screens that was developed in collaboration with B1 stakeholders. Many partners are adopting the recommended CCSA, others are using their current screenings and augmenting it to include all twelve domains. For partner status, see Attachment_B1-8a. In March 2018 additional recommendations were added to the CCSA to include Intimate Partner Violence screening and a Veteran/Military Service screening. The Mental Health Center of Greater Manchester has made great progress in integrating the CCSA into their EMR with plans to implement it organization-wide, beyond the scope of their Integration Enhancement Plan (IEP) in the summer of 2018. Other organizations have made progress and created timelines for implementation. Some of the barriers to implementation include:

- Competing requirements of other external programs, e.g., some of which go beyond the length of the waiver
- Challenge and expense of making change to the EMR, especially for a large hospital system
- Competing initiatives at a given organization, e.g., merger, grants and other program requirements, e.g. HRSA Uniform Data System (UDS)
- Concern for impact on provider workload to address positive screens

B1-8b

Multi-disciplinary core team: Current state assessments revealed that several B1 partners have multi-disciplinary teams, but not to the integrated level as required in the special terms and conditions of the waiver. Throughout this reporting period, Network4Health staff continued to educate partners about the concept of multi-disciplinary core teams in primary and behavioral health settings and integrated care at the B1 workgroup, the B1 Advisory Committee meetings, and the Network4Health All-Partners quarterly meetings. Further discussion about current state, gaps and future state of multi-disciplinary core teams occurred during individual partner meetings.

Partners multi-disciplinary teams vary site to site, based on the organization type and where the organization is on the coordinated/integrated care continuum. For example, Manchester Community

Health Center and Healthcare for the Homeless, both federally qualified health centers, have behavioral and primary care multidisciplinary teams meeting regularly, functioning at high levels at certain sites. Other primary care sites don't have behavioral health providers on site, but are creating relationships to address this. Network4Health worked with its partners during this reporting period to better define and identify opportunities to strengthen the multi-disciplinary core teams. For example, the Mental Health Center of Greater Manchester and Dartmouth Hitchcock have identified multi-disciplinary teams for adult and pediatric practices that include providers to discuss shared patients on a regularly scheduled basis. Center for Life Management has engaged local primary care providers to discuss improved collaboration, similar to their care coordination program with Community Crossroads that addresses the mental, physical and social need of clients with developmental disabilities.

Organization/Provider	Multi-Disciplinary Team Identified	Team List
Catholic Medical Center - Amoskeag Family Practice	Yes	Physician/Associate providers (APRNs, PAs) Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)
Catholic Medical Center - CMC Behavioral Health (BH)	Yes	Psychiatrist Associate providers (APRNs) LICSW LCMHC MLADC MA Department Coordinators BH Director
Catholic Medical Center - Willowbend Family Practice	Yes	Physician/Associate providers (APRNs, PAs) Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)
Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	Yes	Physician/Associate providers (APRNs, PAs) Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)
Catholic Medical Center - Healthcare for the	Yes	Physician/Associate providers (APRNs, PAs)

Homeless – FIT Clinic		Program Assistant RN Care Coordinator BH provider on call (either the MLADC, LMHW or SW) Psychiatric APRN (shared resource)
Catholic Medical Center - Healthcare for the Homeless – New Horizons Clinic	Yes	Physician/Associate providers (APRNs, PAs) RN Care Coordinator Program Assistant Outreach Enrollment Specialist BH provider (MLADC, LMHW or SW) Psychiatric APRN (shared resource)
Center for Life Management	Yes	Community Support Program / "Eligible" Adults • Medical provider (MD or APRN) and RN • Clinician (provided by LICSW, LCMHC, MLADC, MSW. MA, or MS) • Case Manager • Functional Support service provider (FSS) • Supported Employment Specialist (SEP) • Admin Support • Benefits Specialist • Homeless Specialist ACT / Assertive Community Treatment: • Medical provider (MD or APRN) and RN • Clinician (provided by LICSW, LCMHC, MLADC, MSW. MA, or MS) • Case Manager • Functional Support Service provider (FSS) • Supported Employment Specialist (SEP) • Admin Support • Benefits Specialist • Homeless Specialist • Peer Support Specialist Non-Eligible Adults being served through CLM's Adult Outpatient Department (AOP) • Clinician (LICSW, LCMHC, MLADC) • Limited access to med providers • Access to emergency services • Admin support

		Children, Youth, and Family Department • Medical Provider (MD and/or APRN) and RN • Clinician (LICSW, LCMHC, MLADC, LMFT, MSW. MA, or MS) • Case Manager (if eligible) • Functional Support Service Provider (if eligible) • Admin support
Dartmouth-Hitchcock Bedford/Manchester Adult	Yes	Primary Care Provider Associate Provider RN Medical Assistant Secretary Care Coordinator Family Support Specialist Diabetes Educator Coumadin RN Medication Assistance Program Manager
Dartmouth-Hitchcock Bedford/Manchester Pediatric	Yes	Primary Care Provider Associate Provider RN Medical Assistant Secretary Care Coordinator Family Support Specialist Manager Psychiatrist Child Life Specialist
Easterseals NH/ Farnum Center	No	Multi-disciplinary team will be identified as part of their cohort 3 IEP (August/September 2018)
Elliot Health System - Doctors Park Pediatrics, Manchester	Yes	Primary Care Providers Nurses Medical assistants Social Worker Patient services representatives
Elliot Health System – Partial Hospitalization Program	Yes	Currently hiring staff to include: Psychiatric provider/prescriber MLDAC Case Manager Licensed Social Worker RN Peer support workers Outreach workers Client's primary care provider (external)

Families in Transition New Horizons (FITNH) / Family Willows Treatment Center	Yes	Vice President, Clinical and Supportive Services - LICSW, MLADC Program Manager - LICSW, MLADC Intake Coordinator - LADC Therapist - LICSW, MLADC Therapist - LCMHC, MLADC Therapist - MLADC Treatment Coordinator - CRSW Treatment Coordinator - LADC Child Family Therapist - CRSW, MLADC Peer Recovery Support Worker - Pending CRSW Recovery Support Specialists Medical Biller Medication Providers – external, e.g., CMC, Elliot, Dartmouth-Hitchcock
Fusion Health Services, LLC	In progress; new practice currently hiring full staff	Co-Medical Director: MD and APRN Waivered APRNs Psychiatry consult Case Manager (MSW, RN, or equivalent) MS LIDAC/Counselor Practice Manager
Manchester Community Health Center – Hollis Street	Yes	Physician/Associate providers (APRNs, PAs) Nurses Medical Assistants Behavioral Health Consultant's and Case Managers (shared across the three sites, with no Community Health Workers working exclusively with these sites)
Manchester Community Health Center – Child Health Services	Yes	Physician/Associate providers (APRNs, PAs) Nurses Medical Assistants Community Health Workers Behavioral Health Consultants Case Managers
Manchester Community Health Center – East Side Tarrytown Road Practice	Yes	Physician/Associate providers (APRNs, PAs) Nurses Medical Assistants Behavioral Health Consultant's and Case Managers (shared across the three sites, with no Community Health Workers working exclusively with these sites)
Manchester Community Health Center – West Side Neighborhood Health Center	Yes	Physician/Associate providers (APRNs, PAs) Nurses Medical Assistants Behavioral Health Consultant's and Case Managers (shared across the three sites, with no Community Health Workers

		working exclusively with these sites)
Mental Health Center of Greater Manchester	Yes	Adult Level 2-Master's level Clinicians(LICSW and LCMHC), Psychiatrist, APRN, Team Coordinators, Supported Employment Specialist, MLADC Adult Level 3-Master's level Clinicians (LICSW and LCMHC), Psychiatrist, APRN, Team Coordinator, MLADC, Supported Employment Specialist, Housing Outreach Team Specialist, In Shape Health Mentor, Residential Counselor Adult Level 4-Master's Level Clinicians, Team Coordinator, Substance Abuse Specialist, Psychiatrist, APRN, Nurse, Supported Employment Specialist, Housing Outreach Team Specialist, In Shape Health Mentor, Residential Counselor Kids Level 2-Master's Level Clinicians, Psychiatrist or APRN, Team Coordinator, Bachelor Level CM Kids Level 3-Master's Level Clinicians, Psychiatrist or APRN, Team Coordinator, Bachelor Level CM Kids Level 4-Master's Level Clinicians, Psychiatrist, Team Coordinator

B1-8c

Multi-disciplinary core team training;

The training plan, included as Attachment_B1.8c, provides a detailed look at training that will be required of providers for participating practices. Network4Health worked with each of our B1 Integrated Care primary care and behavioral health organizations to create a training plan of desired and required courses in 2018 within each organization's IEP across both their multi-disciplinary core teams and non-clinical staff. Pending training plans are those for Cohort 3, which include the Elliot Health System partial hospitalization program and Easterseals Farnum Center. Cohort 3 training plans will be submitted with their IEPs. This includes a course created by Tracy Tinker, RN, CDE with support from a CDC grant and NH Division of Public Health/Chronic Conditions. The Learning Objectives for this course are as follows:

- Define the latest guidelines for diabetes, hypertension (high blood pressure) and dyslipidemia (cholesterol/lipid disorders)
- Understand the intersection of behavioral health and chronic disease management
- Identify barriers to the integration of behavioral health care and chronic disease management
- Identify and utilize strategies to overcome identified barriers

Network4Health B1 project participants attended a 1.5 day Cherokee Integrated Care Training Academy with members of IDNs 1 and 6 in June. Over 100 participants joined the course to understand the

Cherokee model of integrated care and discuss how to enhance and sustain integration in New Hampshire. For practices choosing not to participate in the Cherokee Trainings or for which not all team members couldn't attend, Mental Health First Aid offerings to meet the Behavioral Health 101 requirement or a custom onsite session for the Behavioral Health and Integration in practice are offered to partners. Network4Health offered the first Mental Health First Aid course on April 11-12, 2018. We intend to offer these quarterly. A second Cherokee training, Behavioral Health Consultant Bootcamp, is scheduled for September 27-28, 2018. Network4Health is also planning this training in cooperation with IDN's 1 and 6, and will open it to other IDNs, space permitting.

A training aimed at strengthening the multidisciplinary core team, and also provides a good example of improving collaboration and networking in IDN4: Network4Health B1 participants began a 5-part BH Integration and Practice Transformation Facilitator Training offered through the New Hampshire Primary Care Behavioral Health Workforce Project (https://sites.google.com/view/nhpcbhworkforce/training/facilitator-training). The Mental Health Center of Greater Manchester offered to host the Network4Health Integrated Care team participants at weekly sessions to view the web-based training together and complete recommended discussion topics at each session. 10 participants from 6 partner organizations were able to join the first session on Monday June 25, 2018.

Training for the Comprehensive Core Standardized Assessment (CCSA) will be unique to each organization's CCSA implementation plan as documented in their Integration Enhancement Plan. Organizations will be expected to provide training within 2018. Catholic Medical Center and Elliot Health System primary care practices have been identified as in need of SBIRT training and implementation. At minimum, organizations will be asked to sign-up for adolescent training through: http://sbirtnh.org/ and adult/general training through: https://www.sbirttraining.com/SBIRT-Core.

Addressing Veterans' health needs holistically is important to Network4Health, and to that end, we work to align with VA initiatives and best practices that include multi-disciplinary teams. Various veteran specific trainings will be made available to our partners. Network4Health's Integrated Healthcare Clinical Director attended VAMC Veterans Community Mental Health Summit addressing mental healthcare for Veterans, where partners such as MHCGM also attended. This was a good opportunity to learn more about Veteran's needs, resources and networking.

B1-8d

Training for staff not providing direct care:

Network4Health has collaborated with a trainer at Manchester Community Health Center to contract for a custom course to be delivered onsite with participating organizations to provide an overview of Integration in Practice and Behavioral Health 101 for all staff. Manchester Community Health Center's Child Health Services currently operates a fully integrated practice and we hope to provide participating organizations ongoing access to knowledge and lessons learned from their transformation efforts.

B1-8e

Network4Health partners identified a schedule for core team case conferences as part of their Integration Enhancement Projects. Both the Elliot Health System Partial Hospitalization Program and Easterseals NH Farnum Center will develop theirs when they submit IEP. Dartmouth-Hitchcock and the Mental Health Center of Greater Manchester have been meeting to develop workflows and plan implementation during late spring and early summer of 2018. Significant progress was made regarding case reviews through current state assessment and identification of barriers during this reporting

period. As part of current state assessments, we found that none of the partners had a standardized approach, workflows or protocols for case reviews between primary care and behavioral health multi disciplinary teams. Ad hoc case reviews are done in some practices by the following partners:

- Manchester Community Health Center
- Catholic Medical Center Primary Care / Catholic Medical Center Behavioral Health Services
- Dartmouth-Hitchcock pediatrics
- Elliot Health System, Primary Care
- The Mental Health Center of Greater Manchester
- Center for Life Management
- Fusion Health Services, LLC
- Easterseals/Farnum Center

During this reporting period, Network4Health made progress by continuing to provide education and discussion with partners about case review evidence-based practices, how it relates to the CCSA and the integrated care continuum. Barriers such as time commitment /productivity down time, clinical and cultural differences between primary care and behavioral health practices and related knowledge deficits, siloed practices, were identified. Network4Health has addressed the productivity down time issue by providing funding for productivity offsets; the clinical and cultural differences and knowledge deficits through education and discussion at the quarterly All-Partners meeting, bi-monthly Network4Health B1 Integrated Healthcare Workgroup, and educational materials; and the siloed practices issue through networking and relationship building activities.

B1-8f

Secured Direct Messaging: Network4Health currently has 16 partners who use direct messaging technologies in daily practice. We have identified multiple gaps however in the use of this technology across entities, consistency of use and the sharing and maintenance of direct addresses. Our current strategy is to promote a more sustainable and cost-effective solution through the use of MedAllies mail. This application will provide a secure method for providers to communicate with health care organizations across the community, including community based organizations to address social determinants of health. Throughout this reporting period, Network4Health staff continued to educate partners about the concept of secured direct messaging in primary and behavioral health settings and integrated care at the B1 workgroup, the B1 Advisory Committee meetings, and the Network4Health All-Partners quarterly meetings. (Please reference A2-3 for greater detail)

B1-8g

Closed Loop Referrals: Closed loop referrals improve the level of care coordination across providers and community based organizations. Currently many partners track referrals manually, inconsistently and with labor intensive and time consuming calls. Network4Health supports the implementation of enabling technology, Par8O, a closed loop referral system. Though *electronic* closed loop referral is required only for those seeking integrated care designations, Network4Health recommends that all B1 partners implement this system. An added benefit is that other IDNs will be using Par8O and that will provide for a greater network of communication.

Throughout this reporting period, Network4Health staff continued to educate partners about the concept of closed loop referrals in primary and behavioral health settings and integrated care at the B1 workgroup, the B1 Advisory Committee meetings, and the Network4Health All-Partners quarterly

meetings. To further strengthen referrals, the B1 workgroup partners are developing a job aid for primary care staff that will help them to better understand mental health levels of care. This will aid in triaging Medicaid members to appropriate mental health providers, and increase the knowledge base of the primary care team. Par8O will enable care teams to schedule appointments directly and see if a patient/client actually had the visit. Implementation of Par8O is expected to begin in Q4 of 2018 with an estimated completion date of March, 2019. (Please reference A2-3 for greater detail)

B1-8h

Documented workflows and/or protocols: The following protocols have been recommended to partners:

- Network4Health CCSA Protocol Recommendations (see Attachment_B1.8h1)
- Network4Health Multi-disciplinary Teams and Closed Loop Referrals Recommended Best Practices (see Attachment_B1.8h2)
    - Guide with recommended best practices and protocols for Multi-Disciplinary Teams and Closed Loop Referrals that includes example workflows, templates and reference information. This was developed by the B1 team to help support B1 participants define the roles and responsibilities of their Behavioral Health/Primary Care Multi-Disciplinary Teams and evaluate processes around Closed Loop Referrals for their integration initiatives.
- NH Center for Excellence: 2nd Edition of Medication Assisted Treatment (MAT) Best Practices, https://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf
- NH Charitable Foundation: SBIRT, https://sbirtnh.org/playbook/
- Institute for Clinical Systems Improvement (ICSI) evidenced-based model for depression: https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/

Progress was made regarding workflows and protocols through IEP development and through education and discussion at the bi-weekly Integrated Care Workgroup meetings, the Integrated Care Advisory Board meeting, and individual meetings with stakeholders around the expectations for documented protocols in organization's Integration Enhancement Plan. As part of current state assessments and workgroup discussion, we found that organizations are working closely with community based organizations, but do not frequently have documented workflows and protocols for their interactions. A challenge across partners is operationalizing best practices and developing workflows that involve limited variability working with different partners.

All B1 partners have been made aware of the need for the below organizational protocols. Network4Health has confirmed that most partners have privacy protocols and robust intake procedures, some of which will be further enhanced by the work being done around the Comprehensive Core Standardized Assessment (CCSA). Network4Health learned that many partners have documented workflows and protocols for the safe transitions from institutional settings, including New Hampshire Hospital, back to primary care, behavioral health and social support service providers. Network4Health is in the process of finalizing the below IDN 4 recommended protocols

during the second half of 2018. The recommendations will be distributed and reviewed with all B1 partners.

- **Interactions between providers and community based organizations**
- **Timely communication**
- **Privacy**
- **Interactions between providers**
- **Safe transitions from institutional settings back to primary care, behavioral health and social support service providers**
- **Intake procedures**
- **Adherence to NH Board of Medicine guidelines on opioid prescribing**

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	IDN Integrated Healthcare: Implementation Plan, Timeline, Milestones and Evaluation Project Plan	Narrative & Spreadsheet (Microsoft Project or similar platform)				
B1-3	IDN Integrated Healthcare: Evaluation Project Targets	Table				
B1-4	IDN Healthcare Integration Workforce Staffing	Table				
B1-5	IDN Healthcare Integration: Budget	Narrative and Spreadsheet				
B1-6	IDN Integrated Healthcare: Key Organizational and Provider Participants	Table				
B1-7	IDN Integrated Healthcare: Organizational leadership sign-off	Table				
B1-8a	All of the following domains must be included in the CCSA: • Demographic	CCSAs (Submit all that are in use)				

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	psychiatrist) • Assigned care managers or community health worker	practice by core team				
B1-8c	Multi-disciplinary core team training for service providers on topics that includes, at minimum: • Diabetes hyperglycemia • Dyslipidemia • Hypertension • Mental health topics (multiple) • SUD topics (multiple)	Training schedule and Table listing all provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by provider type for each reporting period for each training. OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		on progress for each training				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				
B1-8h	Documented work flows and/or protocols that include, at minimum: • Interactions between providers and community based organizations • Timely communication • Privacy, including limitations on information for communications with treating provider and community based organizations • Coordination among case managers (internal and external to IDN) • Safe transitions from institutional settings back to primary care, behavioral health and social support	Work flows and/or Protocols (submit all in use)				

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

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

B1-9a

Achievement of all the requirements of a Coordinated Care Practice: Both Manchester Community Health Center (MCHC) and Catholic Medical Center's Healthcare for the Homeless (HCH) are working towards Integrated Care practice designations. Each has ongoing internal workgroups that developed their Integration Enhancement Plans, and will be continue to meet as they develop workflows, protocols, and implement across sites.

MCHC has been an instrumental partner in developing workflows, protocols, and sharing of best practices, especially providing one on one coaching to partners with questions about their MAT program and experience implementing integrated care delivery.

A challenge both MCHC and HCH face is related to developing a CCSA solution that will align with their other obligations related to UDS, grants, etc., and to their EMR/IT that's managed by CHAN. CHAN manages IT and data reporting for all but one FQHC in New Hampshire and is working to create a solution that will address their multi-faceted needs, and waiver requirements.

The other B1 partner organizations are working towards coordinated care practice designation and have begun to implement their Integration Enhancement Plans(IEPs) - Cohort 1 in May 2018 and Cohort 2 in July 2018. Both Elliot Health Services Partial Hospitalization Program and Easterseals/Farnum Center plan to develop an IEP to submit by September 2018.

B1-9b

Adoption of both Medication Assisted Treatment (MAT) and evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting: As previously reported, Manchester Community Health Center runs a fully implemented Medication Assisted Treatment (MAT) program. Healthcare for the Homeless completed a MAT planning grant in June 2018, and plans to finalize development and start implementation over the next several months with additional clinical support provided by CMC Behavioral Health, which will be funded through their Integration Enhancement Plan.

Healthcare for the Homeless is currently evaluating models such as the Institute for Clinical Systems Improvement (ICSI) evidenced-based model for depression, available at https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/ . Selecting their model for implementation will be one of Healthcare for the Homeless' early implementation milestones.

Manchester Community Health Center has identified the implementation of the Improving Mood – Promoting Access to Collaborative Treatment (IMPACT) model for depression care in their IEP (http://aims.uw.edu/impact-improving-mood-promoting-access-collaborative-treatment); however it is also considering the ICSI model.

B1-9c

At Risk Patients

Network4Health recommends that provider sites coordinate care with the MCOs as part of the multi-disciplinary team, and leverage the data analysis capabilities of the MCOs. All Manchester Community Health Center and Healthcare for the Homeless practice sites use EMR systems that have the capacity to identify at-risk patients and use a variety of methods for identifying at-risk patients based on an

assessment of the presenting and identified risks as evidenced by use of validated tools and clinical findings. These are specific to each partner. As previously provided, Healthcare for the Homeless has a risk identification tool in place. Manchester Community Health Center also already utilizes practice specific logic to identify at risk patients utilizing their EMR. Both organizations have expressed a willingness to make modifications to their risk identification workflows, if needed, to support an expanded definition of high risk or complex patients identified through clinical indicators, positive behavioral health or substance use screenings and the CCSA social determinants of health domains. As mentioned earlier, Network4Health's Shared Care Planning work, including finalization of modifications and standardization of risk identification methodologies, has been delayed. We anticipated making progress in the second half of 2018. In addition to utilizing each practice's EMR for risk identification, Network4Health continues to evaluate the potential use of information provided in the NH Managed Care Organization (MCO) provider portals for incorporation into our identification of at risk patients for shared care planning and encouraged all B1 project participants to ensure access to both MCO portals.

Plan Care/ Monitor/Manage Patients Progress Towards Goals

Both Manchester Community Health Center and Healthcare for the Homeless utilize workflows within their EMRs to set goals and track progress towards meeting these goals. Manchester Community Health Center currently utilizes care plans for specific patient risk groups. Manchester Community Health Center is participating in the ongoing discussions at the Network4Health Integrated Care Workgroup around care plans for use in shared care planning using Collective Medical Technologies PreManage Community product.

While currently utilizing care plans within their EMR, Healthcare for the Homeless is interested in the potential further customization of their care planning templates to support their integrated practice. Healthcare for the Homeless has requested HIT funding for this effort as part of their IEP.

Closed Loop Referrals

Manchester Community Health Center has indicated extensive documented protocols and use of their EMR for monitoring closed loop referrals within their organizations.

As outlined in section A2-3, within Closed Loop Referral Support, Network4Health also presented the option for organizations to consider including the implementation of an automated Closed Loop Referral tool as part of the HIT component of their Integration Enhancement Plan. Network4Health partners are either providing existing or planned protocols in existing tools as part of their Integration Enhancement Plan or indicating their desire to implement the selected Network4Health automated Closed Loop Referral system, Par8O. Network4Health's HIT team is currently in the process of contracting for a product called Par8O. Implementation of Par8O is expected to begin in Q4 of 2018 with an estimated completion date of March, 2019.

Integrated Healthcare Practices - Use of Technology				
Technology Use / Practice Name	***At Risk Patients***	***Plan Care***	***Monitor/manage patient progress toward goals***	***Closed Loop Referrals***
Manchester Community Health Center	*Yes*	*Yes*	*Currently only for certain patients such as prenatal patients and those with diabetes.*	*Yes*

Healthcare for the Homeless	*Yes*	*Yes*	*Yes*	*No – Evaluating automated Closed Loop Referral solution option as part of IEP*

B1-9d

Network4Health B1 project partners identified the community based social support partners with whom they are currently working or with whom they need to develop enhanced collaboration to support the implementation of the CCSA social determinant of health related domains. Both Manchester Community Health Center and Healthcare for the Homeless identified areas for the development of joint protocols or memorandums of understanding in their Integration Enhancement Plans, and identified several specific community based organizations (CBO), such as the Bhutanese Community, Service Link, Families in Transition New Horizons, Meals On Wheels, NH Legal Aid, etc.

Many of these CBOs will also benefit from increased HIT capabilities such as direct secure messaging and closed loop referral system supported by the IDN. The HIT director and B1 team work with partners to identify CBOs who are key stakeholders for their clients/patients.

These CBOs will be invited and encouraged to participate in joint workflow development activities sponsored by Network4Health, and we encourage partners to create more robust relationships and regular communications with CBOs and all stakeholders. A communication plan template was provided to our partners during the IEP development phase.

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

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: • Medication-assisted treatment	Protocols (Submit all in use)				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
		(MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model					
• B1-9c	•	• Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral	• Table listing all providers indicating progress on each process detail				
B1-9d		Documented work flows with community based social support service providers including, at minimum: • Joint service protocols • Communication channels	Work flows (Submit all in use)				

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

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

The below list of Coordinated Care Practices and Integrated Care Practices has been modified based on discussion with the NH DHHS DSRIP team.

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	Up to 18	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	*0 Coordinated Care Practices*	*0 Coordinated Care Practices*	
Integrated Care Practice	Up to 5	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	*0 Integrated Care Practices*	*0 Integrated Care Practices*	

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

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
1	**Catholic Medical Center** - Amoskeag Family Practice	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team - Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions for Behavioral	

			Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	
2	**Catholic Medical Center** – Behavioral Health Practice	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team - Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions for Behavioral Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	
3	**Catholic Medical Center** - Family Health & Wellness Center at Bedford	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team - Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions for Behavioral Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	
4	**Catholic Medical Center** - Willowbend Family Practice	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for CMC primary care practice integration efforts - Formation of a centralized integration project team	

			- Participation in the June 2018 Cherokee Integration Academy by primary care, care coordination and behavioral health services representatives - Significant work done to communicate and gain CMC administrative and clinical leadership buy-in to support implementation of Integration Enhancement Plan - Development of job descriptions for Behavioral Health Patient Navigators and Licensed Mental Health Clinician - Significant internal discussion on the collaboration workflows between CMC primary care and behavioral health services - Assessment of CCSA screenings for implementation with PatientLink. - Regular participation in the Network4Health Integrated Care Workgroup	
5	**Catholic Medical Center** – Healthcare for the Homeless	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for Healthcare for the Homeless integration efforts in the short term and future looking. - Weekly meetings with Network4Health Integration Team to discuss IEP development and all components required for Integrated Care Designation. - Participation in the June 2018 Cherokee Integration Academy	
6	**Center for Life Management –** Behavioral Health	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and all components required for Coordinated Care Designation. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
7	**Dartmouth-Hitchcock -** Adult Primary Care	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in initial workflow discussions with the Mental Health Center of Greater Manchester and separately with Fusion Health Services - Development of job descriptions for Licensed Mental Health Clinicians and Family Support Specialists - Collaboration with other Dartmouth-Hitchcock B1 projects to collaborate on CCSA implementation, job descriptions and workflows to standardize implementation across the Dartmouth system. - Participation in the June 2018 Cherokee	

			Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
8	**Dartmouth-Hitchcock -** Pediatric Primary Care	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in initial workflow discussions with the Mental Health Center of Greater Manchester and separately with Fusion Health Services - Development of job descriptions for Licensed Mental Health Clinicians and Family Support Specialists - Collaboration with other Dartmouth-Hitchcock B1 projects to collaborate on CCSA implementation, job descriptions and workflows to standardize implementation across the Dartmouth system. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
9	**Easterseals NH –** Farnum Center	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Meetings with Network4Health Integration team to discuss IEP development and understanding of Coordinated Care Designation requirements.	
10	**Elliot Health System -** Doctors Park Pediatrics	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan - Meetings with Network4Health Integration Team to discuss IEP development - Participation in the June 2018 Cherokee Integration Academy	
11	**Elliot Health System –** Partial Hospitalization Program	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Focus on implementing PHP; will begin to focus on IEP in Fall 2018	
12	**Families in Transition-New Horizons -** Family Willows Treatment Center	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	

13	**Fusion Health Services**	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
14	**Manchester Community Health Center -** MCHC, Hollis Street	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation.	
15	**Manchester Community Health Center -**MCHC, Tarrytown	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
16	**Manchester Community Health Center -**Westside Neighborhood Health Center	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA	

			- IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
17	**Manchester Community Health Center -** Child Health Services at MCHC	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
18	**Mental Health Center of Greater Manchester –** Behavioral Health	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of coordinated care designation - Regular meetings with Network4Health Integration Team to discuss IEP development and continued IEP implementation planning for all components required for Coordinated Care Designation. - Initiated 2 x workflow discussions with CMC, Dartmouth, Elliot Health Systems and Fusion Health Services - Hired 3 Intensive Transition Team members within reporting period (ITT Coordinator and 2 Case Managers). 2 additional Case Managers to start in July 2018. - Significant work completed on ITT team workflows and patient identification criteria. This will be tested and further refined during initial implementation. - Initial CCSA created within EMR and ready for implementation with ITT team. - Additional EMR modifications to care plan made to support workflow of Intensive Transition Team - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	

Progress Toward Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
1	**Manchester Community Health Center -** MCHC, Hollis Street	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
2	**Manchester Community Health Center -** MCHC, Tarrytown	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
3	**Manchester Community Health Center -** Westside Neighborhood Health Center	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with	

			funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
4	**Manchester Community Health Center -** Child Health Services at MCHC	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan addressing all required components of integrated care designation - IEP implementation planning work completed to physically co-locate multi-disciplinary teams at all locations in second half of 2018 - Hiring plan or re-allocation of existing staff completed and ready to be executed with funding/contracting finalization - Draft case conference scheduled created for all teams - CCSA review meetings held internal - CCSA implementation meeting held with EMR host organization (CHAN), Healthcare for the Homeless and Network4Health HIT and Integrated Healthcare to identify implementation path for CCSA - IMPACT model implementation planning in progress - Participation in the June 2018 Cherokee Integration Academy - Regular participation in the Network4Health Integrated Care Workgroup	
5	**Catholic Medical Center -** Healthcare for the Homeless	Dependent on IEPs by Q1 2018 for Cohort 1 and Q3 2018 for Cohort 2	- Development and submission of an Integration Enhancement Plan as a roadmap for Healthcare for the Homeless integration efforts in the short term and future looking. - Weekly meetings with Network4Health Integration Team to discuss IEP development and all components required for Integrated Care Designation - Participation in the June 2018 Cherokee Integration Academy	

Attachment_B1.2a

B1 - Coordinated Care - 063118

	Task Name	Duration	Start	Finish	Predecessors	% Complete
1	**B1 Integrated Healthcare - Coordinated Care Practices**	430d	03/01/17	10/29/18		87%
2	**Development of Core Deliverables and Process**	430d	03/01/17	10/29/18		87%
3	**Comprehensive Core Standardized Assessment Tool/Process**	240d	03/01/17	01/31/18		97%
4	Develop Comprehensive Core Standardized Assessment Tool	50d	03/01/17	05/09/17		100%
5	Develop Comprehensive Core Standardized Assessment Process	25d	05/10/17	06/13/17	4	100%
6	Refine Comprehensive Core Standardized Assessment Process	165d	06/14/17	01/31/18	5	95%
7	Finalize Comprehensive Core Standardized Assessment Process	0	01/31/18	01/31/18	6	
8	**Depression Screening Tool/Process**	88d	03/01/17	06/30/17		100%
9	Develop Depression Screening Tool	50d	03/01/17	05/09/17		100%
10	Develop Depression Screening Process	25d	05/10/17	06/13/17	9	100%
11	Refine Depression Screening Process	5d	06/14/17	06/20/17	10	100%
12	Finalize Depression Screening Process	8d	06/21/17	06/30/17	11	100%
13	**Shared Care Plan**	430d	03/01/17	10/29/18		76%
14	Develop Shared Care Plan Tool	60d	03/01/17	05/23/17		100%
15	Develop Shared Care Plan Process	127d	05/24/17	11/16/17	14	100%
16	Refine Shared Care Plan Process	8w	08/06/18	10/01/18		0%
17	Finalize Shared Care Plan Process	4w	10/02/18	10/29/18	16	0%
18	**Participant Selection Process**	85d	03/01/17	06/27/17		100%
19	Define Selection Criteria	50d	03/01/17	05/09/17		100%
20	Develop Selection Process	30d	05/10/17	06/20/17	19	100%
21	Select CHI Participants	1w	06/21/17	06/27/17	20	100%
22	Sign CHI Agreement (SSA administration)	22d	07/03/17	08/01/17		100%
23	Sign CHI Agreement (Integration Practice Facilitation)	130d	08/02/17	01/31/18	22	90%
24	**Coordinated Care Practice Cohort 1**	954d	09/15/17	06/14/21		9%
25	**CHI Assessment Cohort 1 Baseline**	54d	09/15/17	11/29/17		100%
26	CHI Assessment Administered	21d	09/15/17	10/13/17		100%
27	CHI Results Collected	32d	10/16/17	11/28/17	26	100%
28	CHI Report Delivered	1d	11/29/17	11/29/17	27	100%
29	**Participant Implementation Process Cohort 1: Initial IEP**	397d	11/30/17	06/21/19		9%
30	Up to 2 Participants Selected for Coordinated Care Practice Cohort 1	3w	11/30/17	12/20/17	28	100%
31	Integration Enhancement Project Team Created	1w	12/21/17	12/27/17	30	100%
32	Integration Enhancement Plan (IEP) Created	43d	12/28/17	02/27/18	31	100%
33	Cohort 1 IEPs Due to Network4Health	0	02/27/18	02/27/18	32	100%
34	Network4Health IEP Funding Review	31d	02/28/18	04/11/18	33	100%
35	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	04/12/18	04/12/18	34	100%
36	Intiate Integration Enhancement Plan - (12 months)	253d	06/01/18	05/31/19	35FS +34d	
37	3 month Status Report and Lessons Learned Due	79d	06/01/18	09/21/18	36SS	
38	6 month Status Report and Lessons Learned Due	142d	06/01/18	12/21/18	36SS	
39	9 month Status Report and Lessons Learned Due	204d	06/01/18	03/22/19	36SS	

Attachment_B1.2a

	Task Name	Duration	Start	Finish	Predecessors	% Complete
40	12 month Status Report and Lessons Learned Due	268d	06/01/18	06/21/19	36SS	
41	**CHI Assessment Cohort 1 Follow-up 1 (Progress Assessment Checkpoint)**	71d	05/14/18	08/22/18		35%
42	CHI Assessment Administered	10w	05/14/18	07/24/18		50%
43	CHI Results Analysis	20d	07/25/18	08/21/18	42	
44	CHI Report Delivered	1d	08/22/18	08/22/18	43	
45	**CHI Assessment Cohort 1 Follow-up 2, Cohort 2 Follow-up 1 (Progress Assessment Checkpoint)**	51d	10/01/18	12/12/18		
46	CHI Assessment Administered	6w	10/01/18	11/09/18		
47	CHI Results Collected	20d	11/12/18	12/11/18	46	
48	CHI Report Delivered	1d	12/12/18	12/12/18	47	
49	**Participant Implementation Process Cohort 1 & 2 (combined) IEP Renewal**	314d	03/25/19	06/16/20		
50	Status Report and CHI Assessment Results Reviewed	2w	03/25/19	04/05/19	39	
51	IEP Modifications and Continued Funding Requests Reviewed	2w	03/25/19	04/05/19	39	
52	IEP Continuation and Funding Continuation Confirmation	1d	04/08/19	04/08/19	51	
53	Integration Enhancement Plan Continuation- (12 months)	253d	06/03/19	05/29/20	36	
54	3 month Status Report and Lessons Learned Due	14w	06/03/19	09/09/19	53SS	
55	6 month Status Report and Lessons Learned Due	27w	06/03/19	12/11/19	53SS	
56	9 month Status Report and Lessons Learned Due	200d	06/03/19	03/16/20	53SS	
57	12 month Status Report and Lessons Learned Due	265d	06/03/19	06/16/20	53SS	
58	**CHI Assessment Cohort 1 Follow-up 3, Cohort 2 Follow-up 2 (Progress Assessment Checkpoint)**	36d	10/29/19	12/19/19		
59	CHI Assessment Administered	3w	10/29/19	11/18/19	55FS -30d	
60	CHI Results Collected	20d	11/19/19	12/18/19	59	
61	CHI Report Delivered	1d	12/19/19	12/19/19	60	
62	**Participant Implementation Process Cohort 1 & 2 IEP Renewal**	318d	03/17/20	06/14/21		
63	Status Report and CHI Assessment Results Reviewed	2w	03/17/20	03/30/20	56	
64	IEP Modifications and Continued Funding Requests Reviewed	2w	03/17/20	03/30/20	56	
65	IEP Continuation and Funding Continuation Confirmation	1d	03/31/20	03/31/20	64	
66	Integration Enhancement Plan Continuation- (12 months)	255d	06/01/20	05/31/21	53	
67	3 month Status Report and Lessons Learned Due	14w	06/01/20	09/04/20	66SS	
68	6 month Status Report and Lessons Learned Due	27w	06/01/20	12/09/20	66SS	
69	9 month Status Report and Lessons Learned Due	200d	06/01/20	03/15/21	66SS	
70	12 month Status Report and Lessons Learned Due	265d	06/01/20	06/14/21	66SS	
71	**Coordinated Care Practices Cohort 2**	333d	03/01/18	06/21/19		31%
72	**CHI Assessment Cohort 2 Baseline**	41d	03/01/18	04/26/18		49%
73	CHI Assessment Administered	20d	03/01/18	03/28/18		100%
74	CHI Results Collected	20d	03/29/18	04/25/18	73	
75	CHI Report Delivered	1d	04/26/18	04/26/18	74	
76	**Participant Implementation Process Cohort 2 Initial IEP**	333d	03/01/18	06/21/19		29%
77	Up to 2 Participants Selected for Coordinated Care Practice Cohort 2	0	03/01/18	03/01/18		100%
78	Integration Enhancement Project Team Created	4d	03/01/18	03/06/18	77	100%
79	Integration Enhancement Plan (IEP) Created	67d	03/07/18	06/08/18	78	100%

	Task Name	Duration	Start	Finish	Predecessors	% Complete
80	Cohort 1 IEPs Due to Network4Health	0	06/08/18	06/08/18	79	100%
81	Network4Health IEP Funding Review	22d	06/11/18	07/11/18	80	100%
82	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board/Steering Committee)	1d	07/12/18	07/12/18	81	100%
83	Intiate Integration Enhancement Plan - (10 months)	1d	08/01/18	08/01/18	82FS +13d	
84	3 month Status Report and Lessons Learned Due	1d	09/21/18	09/21/18		
85	6 month Status Report and Lessons Learned Due	1d	12/21/18	12/21/18		
86	9 month Status Report and Lessons Learned Due	1d	03/22/19	03/22/19		
87	12 month Status Report and Lessons Learned Due	226d	08/01/18	06/21/19		
88	Transition Cohort 2 to Cohort 1 Timeline	0	06/21/19	06/21/19	87	
89	Transition Cohort 2 to CHI Assessment Follow-up Timeline in alignment with Cohort 1	0	10/01/18	10/01/18		
90	**Evaluation Metrics Reporting (Data - per approved metrics)**	913d	07/01/17	01/29/21		29%
91	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/31/18		100%
92	Prepare evaluation plan measures	152d	07/01/17	01/30/18		100%
93	Submit	1d	01/31/18	01/31/18	92	100%
94	On-going data reporting for period ending 06/29/2018	150d	01/01/18	07/31/18		100%
95	Prepare evaluation plan measures	149d	01/01/18	07/30/18		100%
96	Submit	1d	07/31/18	07/31/18	95	100%
97	On-going data reporting for period ending 12/31/2018	148d	07/01/18	01/31/19		
98	Prepare evaluation plan measures	147d	07/01/18	01/30/19		
99	Submit	1d	01/31/19	01/31/19	98	
100	On-going data reporting for period ending 06/29/2019	151d	01/01/19	07/31/19		
101	Prepare evaluation plan measures	150d	01/01/19	07/30/19		
102	Submit	1d	07/31/19	07/31/19	101	
103	On-going data reporting for period ending 12/31/2019	149d	07/01/19	01/31/20		
104	Prepare evaluation plan measures	148d	07/01/19	01/30/20		
105	Submit	1d	01/31/20	01/31/20	104	
106	On-going data reporting for period ending 06/29/2020	152d	01/01/20	07/31/20		
107	Prepare evaluation plan measures	151d	01/01/20	07/30/20		
108	Submit	1d	07/31/20	07/31/20	107	
109	On-going data reporting for period ending 12/31/2020	147d	07/01/20	01/29/21		
110	Prepare evaluation plan measures	146d	07/01/20	01/28/21		
111	Submit	1d	01/29/21	01/29/21	110	
112	**Process Milestones**	1049d	01/01/17	02/08/21		37%
113	**Milestones for period ending 06/31/2017**	152d	01/01/17	07/31/17		100%
114	Develop Implementation Plan	152d	01/01/17	07/31/17		100%
115	Implementation timeline	152d	01/01/17	07/31/17		100%
116	Budget	152d	01/01/17	07/31/17		100%
117	Workforce Plan	152d	01/01/17	07/31/17		100%
118	Participant Selection	152d	01/01/17	07/31/17		100%
119	Organizational Leadership Sign-off	152d	01/01/17	07/31/17		100%

Attachment_B1.2a

	Task Name	Duration	Start	Finish	Predecessors	% Complete
120	**Milestones for period ending 12/31/2017**	153d	07/01/17	01/31/18		100%
121	Up to 20 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/17	01/31/18		100%
122	Up to 2 participants have demonstrated progress towards Integrated Care Practice	153d	07/01/17	01/31/18		100%
123	**Milestones for period ending 06/31/2018**	151d	01/01/18	08/01/18		100%
124	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	151d	01/01/18	08/01/18		100%
125	Up to 2 participants have demonstrated progress towards Integrated Care Practice	151d	01/01/18	08/01/18		100%
126	**Milestones for period ending 12/31/2018**	154d	07/01/18	02/08/19		
127	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	154d	07/01/18	02/08/19		
128	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	154d	07/01/18	02/08/19		
129	**Milestones for period ending 06/31/2019**	152d	01/01/19	08/01/19		
130	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	152d	01/01/19	08/01/19		
131	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	152d	01/01/19	08/01/19		
132	**Milestones for period ending 12/31/2019**	155d	07/01/19	02/10/20		
133	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	155d	07/01/19	02/10/20		
134	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	155d	07/01/19	02/10/20		
135	**Milestones for period ending 06/29/20**	153d	01/01/20	08/03/20		
136	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	01/01/20	08/03/20		
137	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	01/01/20	08/03/20		
138	**Milestones for period ending 12/31/2020**	153d	07/01/20	02/08/21		
139	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/20	02/08/21		
140	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	07/01/20	02/08/21		
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Attachment_B1.2b

B1 - Integrated Care - 063118

	Task Name	Duration	Start	Finish	Predecessors	% Complete
1	**B1 Integrated Healthcare - Integrated Care Practices**	430d	03/01/17	10/29/18		91%
2	**Development of Core Deliverables and Process**	430d	03/01/17	10/29/18		91%
3	**Comprehensive Core Standardized Assessment Tool/Process**	240d	03/01/17	01/31/18		97%
4	Develop Comprehensive Core Standardized Assessment Tool	50d	03/01/17	05/09/17		100%
5	Develop Comprehensive Core Standardized Assessment Process	25d	05/10/17	06/13/17	4	100%
6	Refine Comprehensive Core Standardized Assessment Process	165d	06/14/17	01/31/18	5	95%
7	Finalize Comprehensive Core Standardized Assessment Process	0	01/31/18	01/31/18	6	
8	**Depression Screening Tool/Process**	88d	03/01/17	06/30/17		100%
9	Develop Depression Screening Tool	50d	03/01/17	05/09/17		100%
10	Develop Depression Screening Process	25d	05/10/17	06/13/17	9	100%
11	Refine Depression Screening Process	5d	06/14/17	06/20/17	10	100%
12	Finalize Depression Screening Process	8d	06/21/17	06/30/17	11	100%
13	**Shared Care Plan**	430d	03/01/17	10/29/18		76%
14	Develop Shared Care Plan Tool	60d	03/01/17	05/23/17		100%
15	Develop Shared Care Plan Process	127d	05/24/17	11/16/17	14	100%
16	Refine Shared Care Plan Process	8w	08/06/18	10/01/18		0%
17	Finalize Shared Care Plan Process	4w	10/02/18	10/29/18	16	0%
18	**MAT Treatment Program**	363d	03/01/17	07/25/18		100%
19	Research MAT Model	60d	03/01/17	05/23/17		100%
20	Develop MAT Plan/Protocol	200d	05/24/17	02/28/18	19	100%
21	Refine MAT Plan/Protocol	100d	03/01/18	07/20/18	20	100%
22	Finalize MAT Plan/Protocol	3d	07/23/18	07/25/18	21	100%
23	**Participant Selection Process**	85d	03/01/17	06/27/17		100%
24	Define Selection Criteria	50d	03/01/17	05/09/17		100%
25	Develop Selection Process	30d	05/10/17	06/20/17	24	100%
26	Select CHI Participants	1w	06/21/17	06/27/17	25	100%
27	Sign CHI Agreement (SSA administration)	22d	07/03/17	08/01/17		100%
28	Sign CHI Agreement (Integration Practice Facilitation)	130d	08/02/17	01/31/18	27	90%
29	**Integrated Practice Cohort 1 (1 practice)**	954d	09/15/17	06/14/21		9%
30	**CHI Assessment Cohort 1 Baseline**	54d	09/15/17	11/29/17		100%
31	CHI Assessment Administered	21d	09/15/17	10/13/17		100%
32	CHI Results Collected	32d	10/16/17	11/28/17	31	100%
33	CHI Report Delivered	1d	11/29/17	11/29/17	32	100%
34	**Participant Implementation Process Cohort 1: Initial IEP**	397d	11/30/17	06/21/19		9%
35	Up to 2 Participants Selected for Integrated Care Practice Cohort 1	3w	11/30/17	12/20/17	33	100%
36	Integration Enhancement Project Team Created	1w	12/21/17	12/27/17	35	100%
37	Integration Enhancement Plan (IEP) Created	43d	12/28/17	02/27/18	36	100%
38	Cohort 1 IEPs Due to Network4Health	0	02/27/18	02/27/18	37	100%
39	Network4Health IEP Funding Review	31d	02/28/18	04/11/18	38	100%

	Task Name	Duration	Start	Finish	Predecessors	% Complete
40	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	04/12/18	04/12/18	39	100%
41	Intiate Integration Enhancement Plan - (12 months)	253d	06/01/18	05/31/19	40FS +34d	
42	3 month Status Report and Lessons Learned Due	79d	06/01/18	09/21/18	41SS	
43	6 month Status Report and Lessons Learned Due	142d	06/01/18	12/21/18	41SS	
44	9 month Status Report and Lessons Learned Due	204d	06/01/18	03/22/19	41SS	
45	12 month Status Report and Lessons Learned Due	268d	06/01/18	06/21/19	41SS	
46	**CHI Assessment Cohort 1 Follow-up 1 (Progress Assessment Checkpoint)**	71d	05/14/18	08/22/18		35%
47	CHI Assessment Administered	10w	05/14/18	07/24/18		50%
48	CHI Results Analysis	20d	07/25/18	08/21/18	47	
49	CHI Report Delivered	1d	08/22/18	08/22/18	48	
50	**CHI Assessment Cohort 1 Follow-up 2, Cohort 2 Follow-up 1 (Progress Assessment Checkpoint)**	51d	10/01/18	12/12/18		
51	CHI Assessment Administered	6w	10/01/18	11/09/18		
52	CHI Results Collected	20d	11/12/18	12/11/18	51	
53	CHI Report Delivered	1d	12/12/18	12/12/18	52	
54	**Participant Implementation Process Cohort 1 & 2 (combined) IEP Renewal**	314d	03/25/19	06/16/20		
55	Status Report and CHI Assessment Results Reviewed	2w	03/25/19	04/05/19	44	
56	IEP Modifications and Continued Funding Requests Reviewed	2w	03/25/19	04/05/19	44	
57	IEP Continuation and Funding Continuation Confirmation	1d	04/08/19	04/08/19	56	
58	Integration Enhancement Plan Continuation- (12 months)	253d	06/03/19	05/29/20	41	
59	3 month Status Report and Lessons Learned Due	14w	06/03/19	09/09/19	58SS	
60	6 month Status Report and Lessons Learned Due	27w	06/03/19	12/11/19	58SS	
61	9 month Status Report and Lessons Learned Due	200d	06/03/19	03/16/20	58SS	
62	12 month Status Report and Lessons Learned Due	265d	06/03/19	06/16/20	58SS	
63	**CHI Assessment Cohort 1 Follow-up 3, Cohort 2 Follow-up 2 (Progress Assessment Checkpoint)**	36d	10/29/19	12/19/19		
64	CHI Assessment Administered	3w	10/29/19	11/18/19	60FS -30d	
65	CHI Results Collected	20d	11/19/19	12/18/19	64	
66	CHI Report Delivered	1d	12/19/19	12/19/19	65	
67	**Participant Implementation Process Cohort 1 & 2 IEP Renewal**	318d	03/17/20	06/14/21		
68	Status Report and CHI Assessment Results Reviewed	2w	03/17/20	03/30/20	61	
69	IEP Modifications and Continued Funding Requests Reviewed	2w	03/17/20	03/30/20	61	
70	IEP Continuation and Funding Continuation Confirmation	1d	03/31/20	03/31/20	69	
71	Integration Enhancement Plan Continuation- (12 months)	255d	06/01/20	05/31/21	58	
72	3 month Status Report and Lessons Learned Due	14w	06/01/20	09/04/20	71SS	
73	6 month Status Report and Lessons Learned Due	27w	06/01/20	12/09/20	71SS	
74	9 month Status Report and Lessons Learned Due	200d	06/01/20	03/15/21	71SS	
75	12 month Status Report and Lessons Learned Due	265d	06/01/20	06/14/21	71SS	
76	**Integrated Care Practice Cohort 2 (up to 2 Practices)**	333d	03/01/18	06/21/19		31%
77	**CHI Assessment Cohort 2 Baseline**	41d	03/01/18	04/26/18		49%
78	CHI Assessment Administered	20d	03/01/18	03/28/18		100%
79	CHI Results Collected	20d	03/29/18	04/25/18	78	

Attachment_B1.2b

	Task Name	Duration	Start	Finish	Predecessors	% Complete
80	CHI Report Delivered	1d	04/26/18	04/26/18	79	
81	**Participant Implementation Process Cohort 2 Initial IEP**	333d	03/01/18	06/21/19		29%
82	Up to 2 Participants Selected for Integrated Care Practice Cohort 2	0	03/01/18	03/01/18		100%
83	Integration Enhancement Project Team Created	4d	03/01/18	03/06/18	82	100%
84	Integration Enhancement Plan (IEP) Created	67d	03/07/18	06/08/18	83	100%
85	Cohort 1 IEPs Due to Network4Health	0	06/08/18	06/08/18	84	100%
86	Network4Health IEP Funding Review	22d	06/11/18	07/11/18	85	100%
87	IEP Funding Confirmation (B1 Integrated Care Project Advisory Board/Steering Committee)	1d	07/12/18	07/12/18	86	100%
88	Intiate Integration Enhancement Plan - (10 months)	1d	08/01/18	08/01/18	87FS +13d	
89	3 month Status Report and Lessons Learned Due	1d	09/21/18	09/21/18		
90	6 month Status Report and Lessons Learned Due	1d	12/21/18	12/21/18		
91	9 month Status Report and Lessons Learned Due	1d	03/22/19	03/22/19		
92	12 month Status Report and Lessons Learned Due	226d	08/01/18	06/21/19		
93	Transition Cohort 2 to Cohort 1 Timeline	0	06/21/19	06/21/19	92	
94	Transition Cohort 2 to CHI Assessment Follow-up Timeline in alignment with Cohort 1	0	10/01/18	10/01/18		
95	**Evaluation Metrics Reporting (Data - per approved metrics)**	913d	07/01/17	01/29/21		29%
96	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/31/18		100%
97	Prepare evaluation plan measures	152d	07/01/17	01/30/18		100%
98	Submit	1d	01/31/18	01/31/18	97	100%
99	On-going data reporting for period ending 06/29/2018	150d	01/01/18	07/31/18		100%
100	Prepare evaluation plan measures	149d	01/01/18	07/30/18		100%
101	Submit	1d	07/31/18	07/31/18	100	100%
102	On-going data reporting for period ending 12/31/2018	148d	07/01/18	01/31/19		
103	Prepare evaluation plan measures	147d	07/01/18	01/30/19		
104	Submit	1d	01/31/19	01/31/19	103	
105	On-going data reporting for period ending 06/29/2019	151d	01/01/19	07/31/19		
106	Prepare evaluation plan measures	150d	01/01/19	07/30/19		
107	Submit	1d	07/31/19	07/31/19	106	
108	On-going data reporting for period ending 12/31/2019	149d	07/01/19	01/31/20		
109	Prepare evaluation plan measures	148d	07/01/19	01/30/20		
110	Submit	1d	01/31/20	01/31/20	109	
111	On-going data reporting for period ending 06/29/2020	152d	01/01/20	07/31/20		
112	Prepare evaluation plan measures	151d	01/01/20	07/30/20		
113	Submit	1d	07/31/20	07/31/20	112	
114	On-going data reporting for period ending 12/31/2020	147d	07/01/20	01/29/21		
115	Prepare evaluation plan measures	146d	07/01/20	01/28/21		
116	Submit	1d	01/29/21	01/29/21	115	
117	**Process Milestones**	1049d	01/01/17	02/08/21		37%
118	**Milestones for period ending 06/31/2017**	152d	01/01/17	07/31/17		100%
119	Develop Implementation Plan	152d	01/01/17	07/31/17		100%

Attachment_B1.2b

	Task Name	Duration	Start	Finish	Predecessors	% Complete
120	Implementation timeline	152d	01/01/17	07/31/17		100%
121	Budget	152d	01/01/17	07/31/17		100%
122	Workforce Plan	152d	01/01/17	07/31/17		100%
123	Participant Selection	152d	01/01/17	07/31/17		100%
124	Organizational Leadership Sign-off	152d	01/01/17	07/31/17		100%
125	**Milestones for period ending 12/31/2017**	153d	07/01/17	01/31/18		100%
126	Up to 20 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/17	01/31/18		100%
127	Up to 2 participants have demonstrated progress towards Integrated Care Practice	153d	07/01/17	01/31/18		100%
128	**Milestones for period ending 06/31/2018**	151d	01/01/18	08/01/18		100%
129	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	151d	01/01/18	08/01/18		100%
130	Up to 2 participants have demonstrated progress towards Integrated Care Practice	151d	01/01/18	08/01/18		100%
131	**Milestones for period ending 12/31/2018**	154d	07/01/18	02/08/19		
132	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	154d	07/01/18	02/08/19		
133	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	154d	07/01/18	02/08/19		
134	**Milestones for period ending 06/31/2019**	152d	01/01/19	08/01/19		
135	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	152d	01/01/19	08/01/19		
136	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	152d	01/01/19	08/01/19		
137	**Milestones for period ending 12/31/2019**	155d	07/01/19	02/10/20		
138	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	155d	07/01/19	02/10/20		
139	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	155d	07/01/19	02/10/20		
140	**Milestones for period ending 06/29/20**	153d	01/01/20	08/03/20		
141	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	01/01/20	08/03/20		
142	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	01/01/20	08/03/20		
143	**Milestones for period ending 12/31/2020**	153d	07/01/20	02/08/21		
144	Up to 18 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/20	02/08/21		
145	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	07/01/20	02/08/21		
146						
147						
148						
149						
150						
151						
152						
153						
154						
155						

Attachment_B1.8a

Primary Care & Behavioral Health Organizations	Demographic Information	Physical Health Review	Housing Assessment	Educational Attainment	Family and Support Services	Access to legal services	Developmental Screenings
Catholic Medical Center - Amoskeag Family Practice	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - CMC Behavioral Health	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Hooksett Internal Medicine	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Willowbend Family Practice	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Healthcare for the Homeless	Yes	Yes	Yes	Progress	Progress	Progress	Progress
Center for Life Management	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Dartmouth-Hitchcock Bedford/Manchester Adult	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Dartmouth-Hitchcock Bedford/Manchester Pediatric	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Easterseals NH/ Farnum Center	No	No	No	No	No	No	No
Elliot Health System - Doctors Park Pediatrics, Manchester	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Partial Hospitalization Program	Progress	Progress	Progress	Progress	Progress	Progress	Progress
Families in Transition - New Horizons, Willows Treatment Center	Yes	Progress	Progress	Progress	Progress	Progress	Progress
Manchester Community Health Center	Yes	Yes	Progress	Progress	Yes	Progress	Progress
Mental Health Center of Greater Manchester	Yes	Progress	Progress	Progress	Yes	Progress	Progress

Attachment_B1.8a

Primary Care & Behavioral Health Organizations	Functional status assessment	Employment or entitlement	Depression Screening	Suicide risk assessment	Substance Use Review
Catholic Medical Center - Amoskeag Family Practice	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - CMC Behavioral Health	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Hooksett Internal Medicine	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Willowbend Family Practice	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Healthcare for the Homeless	Progress	Progress	Yes	Yes	Yes
Center for Life Management	Yes	Progress	Yes	Yes	Yes
Dartmouth-Hitchcock Bedford/Manchester Adult	Progress	Progress	Yes	Yes	Yes
Dartmouth-Hitchcock Bedford/Manchester Pediatric	Progress	Progress	Yes	Yes	Yes
Easterseals NH/ Farnum Center	No	No	No	No	No
Elliot Health System - Doctors Park Pediatrics, Manchester	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Partial Hospitalization Program	Progress	Progress	Progress	Progress	Progress
Families in Transition - New Horizons, Willows Treatment Center	Progress	Progress	Yes	Yes	Yes
Manchester Community Health Center	Progress	Progress	Yes	Yes	Yes
Mental Health Center of Greater Manchester	Progress	Progress	Yes	Yes	Yes

B1 Training Plan

			B1: Core Series				Behavioral Health Series				Chronic Disease Series	Additional Organization Specific Courses
	TRAININGS	Staff	Cherokee Integration Academy	Cherokee Team Based Integrated Care Bootcamp	Core Standardized Assessment	Integration in Practice / Behavioral Health 101	Mental Health First Aid	SBIRT	Cultural Competence	Motivational Interviewing	Diabetes/ Hyperglycemia Dyslipidemia Hypertension	
							B1: Integration Participants					
	Catholic Medical Center											
BH	CMC Behavioral Health	Clinical Staff: 7 Non-clinical staff: 5	Completed 6/14/18-6/15/18 Non-clinical staff: 2	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	Optional	N/A	Required by 12/31/18	Optional	Scheduled 8/7/18	Southern NH AHEC Community Health Worker Training x 3, in 2018 or 2019 when Behavioral Health Navigators are hired.
Primary Care	Family Health & Wellness Center at Bedford	Clinical Staff: 14 Non-clinical staff: 4	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 3	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	-Completed 4/11-4/12/18 course supported by E4 ITCOD project Clinical Staff: 3 Non-clinical staff: 2 - Catholic Medical Center Primary Care is funded to hold a CMC specific course for up to 20 participants to be trained in Mental Health First Aid prior to 5/31/19.	Required by 12/31/18	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired, else prior to 5/31/19)	Southern NH AHEC Community Health Worker Training x 3, in 2018 or 2019 when Behavioral Health Navigators are hired.
Primary Care	Highlander Way Internal Medicine	Clinical Staff: 4 Non-clinical staff: 3		Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	Catholic Medical Center Primary Care is funded to hold a CMC specific course for up to 20 participants to be trained in Mental Health First Aid prior to 5/31/19.	Required by 12/31/18	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired)	Southern NH AHEC Community Health Worker Training x 3, in 2018 or 2019 when Behavioral Health Navigators are hired.
Primary Care	Hooksett Internal Medicine	Clinical Staff: 5 Non-clinical staff: 2		Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	Catholic Medical Center Primary Care is funded to hold a CMC specific course for up to 20 participants to be trained in Mental Health First Aid prior to 5/31/19.	Required by 12/31/18	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired, else prior to 5/31/19)	Southern NH AHEC Community Health Worker Training x 3, in 2018 or 2019 when Behavioral Health Navigators are hired.
Primary Care	Willowbend Family Practice	Clinical Staff: 15 Non-clinical staff: 6		Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	-Completed 4/12/18 course supported by E4 ITCOD project Clinical Staff: 2 -Catholic Medical Center Primary Care is funded to hold a CMC specific course for up to 20 participants to be trained in Mental Health First Aid prior to 5/31/19.	Required by 12/31/18	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired)	Southern NH AHEC Community Health Worker Training x 3, in 2018 or 2019 when Behavioral Health Navigators are hired.
Primary Care	Healthcare for the Homeless	TBD - Q3 2018	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 2	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18		Required by 12/31/18	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired, else prior to 5/31/19)	
	Dartmouth Hitchcock											

B1 Training Plan

			B1: Core Series				Behavioral Health Series				Chronic Disease Series	Additional Organization Specific Courses
	TRAININGS	**Staff**	**Cherokee Integration Academy**	**Cherokee Team Based Integrated Care Bootcamp**	**Core Standardized Assessment**	**Integration in Practice / Behavioral Health 101**	**Mental Health First Aid**	**SBIRT**	**Cultural Competence**	**Motivational Interviewing**	**Diabetes/ Hyperglycemia Dyslipidemia Hypertension**	
B1: Integration Participants												
Primary Care	Dartmouth-Hitchcock Manchester	Clinical Staff: 144 Non-clinical staff: 35	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 2	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	Optional	Previously Implemented. Optional refresher course offered prior to 5/31/19	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired, else prior to 5/31/19)	None
Primary Care	Dartmouth-Hitchcock Bedford	Clinical Staff: 31 Non-clinical staff:8	Completed 6/14/18-6/15/18 Clinical staff: 1	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	Optional	Previously Implemented. Optional refresher course offered prior to 5/31/19	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired, else prior to 5/31/19)	None
	Elliot Health System											
Primary Care	Elliot Health System Primary Care - Doctors Park Pediatrics	TBD - Q3 2018	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 3	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	Optional	N/A - Previously implemented	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired, else prior to 5/31/19)	
SUD	Elliot Health System Partial Hospitalization Program	TBD - Q3 2018		Optional, scheduled for 9/27/18-9/28/18	All training is TBD based on Integration Enhancement Plan in Q3 2018.							
Primary Care/BH	**Manchester Community Health Center - All Practice Sites**	Clinical Staff: 175 Non-clinical staff: 50	Completed 6/14/18-6/15/18 Clinical staff: 2 Non-clinical staff: 1	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Not required - organization already integrated	Not required	N/A - Previously implemented	Required by 12/31/18	Optional - Offered twice in September through the E4 ITCOD Project	Required by 12/31/18 for Behavioral Health Staff (if hired, else prior to 5/31/19)	-6 staff at Southern NH AHEC Community Health Worker Training prior to 5/31/19 -IMPACT or other training for evidence based depression training prior to 5/31/19 -Required to select 1 x Substance Use or Behavioral Health Training for all practices sites prior to 5/31/19
BH	**Mental Health Center of Greater Manchester**	Clinical Staff: 297 Non-clinical staff: 125	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 4	Optional, scheduled for 9/27/18-9/28/18	Required by 12/31/18	Required by 12/31/18	Optional	N/A	Completed. Yearly internal course provided to all staff.	Optional	Session 1 Scheduled 8/21/18 Session 2 - TBD October/November 2018	-Funding provided for any of the following trainings prior to 5/31/19: • Motivational Interviewing • Cherokee Integrated Care Addictions Training • ADT Messages • LEAP • Zero-Suicide Core trainings (Overview, Risk assessment, safety planning, Transitions of care) • Stigma • CBT-SP • Collaborative Assessment and Management of Suicide (CAMS) • Trauma Informed Care • Stages of Change
BH	**Center for Life Management**	TBD - Q3 2018	Completed 6/14/18-6/15/18 Clinical staff: 4 Non-clinical staff: 2	Optional, scheduled for 9/27/18-9/28/18	All training is TBD based on Integration Enhancement Plan in Q3 2018.							
Primary Care	**Fusion Health Services**	TBD - Q3 2018	Completed 6/14/18-6/15/18 Clinical staff: 1	Optional, scheduled for 9/27/18-9/28/18	All training is TBD based on Integration Enhancement Plan in Q3 2018.							
SUD	**Families In Transition - New Horizons, Willows Treatment Center**	TBD - Q3 2018	Completed 6/14/18-6/15/18 Clinical staff: 1 Non-clinical staff: 1	Optional, scheduled for 9/27/18-9/28/18	All training is TBD based on Integration Enhancement Plan in Q3 2018.							
SUD	**Easterseals NH Farnum Center**	TBD - Q3 2018	Completed 6/14/18-6/15/18 Non-clinical staff: 2	Optional, scheduled for 9/27/18-9/28/18	All training is TBD based on Integration Enhancement Plan in Q3 2018.							

DSRIP 1115 Medicaid Waiver Program

IDN 4 Comprehensive Core Standardized Assessment

Protocol Recommendations

Comprehensive *Core Standardized Assessment (CCSA)*

12 Domains

1. Demographic / Race & Ethnicity

2. Medical
Not prescribed/ medical history

3. Substance Use
including tobacco use and SBIRT screening

4. Housing & Transportation

5. Family & Support Services

6. Education (and Health Literacy)

7. Employment and Entitlement

8. Legal

9. Suicide Risk

10. Functional Status
- Activities of Daily Living
- Instrumental Activities of Daily Living
- Cognitive Functioning

Depression Screening:
PHQ 3 & 9

Pediatric Specific Developmental and Behavioral Screenings

NETWORK 4 HEALTH

Prior to administering CCSA Screening

Domain 6 - Education & Health Literacy

Recommended Screening immediately prior to the individual completing the CCSA:

1. Ask if the individual is best served in a language other than English
    1. If yes, what Language are you most comfortable speaking?

_Spanish_Portugese_ Chinese_ German_ Greek_ Hindi_ Italian_ Russian_ Arabic_ French
_ Vietnamese _Other

2. How confident are you filling out forms by yourself?
    1. __1. Not at all
    2. __2. A little bit
    3. __3. Somewhat
    4. __4. Quite a bit
    5. __5. Extremely

Recommended Action:

•If 1 is yes, utilize "I speak" card to identify language spoken and assess support system for person able to interpret for individual, or if 2 is somewhat or less, access interpreter. Note: health care organizations must provide free interpretation under Title VI.

•Provide CCSA and information in individual's language (interpreted)

•**Screening Sources:**

•Uniform Data System (UDS) required reporting; http://www.bphcdata.net

•Also generally aligns with NH DHHS Office of Health Equity

NETWORK 4 HEALTH

Domain 1 – Demographic / Race & Ethnicity :
Veteran / Military Service Screening

Recommended screening:

1. Have you or a family member ever served in the military?

__a. No

__b. Yes

Recommended Action:

- When the response is "yes," you may consider thanking them for their service
- Use interview to explore, assess and identify if additional screening is indicated. As appropriate, further assess using the "Ask the Question NH screening tool: http://askthequestionnh.com/wp-content/uploads/PTS_TBI_MST_screenings.pdf

You may also then be able to:

- find out more about the service experience that will facilitate appropriate diagnosis, treatment planning, and referrals.
- Link to any needed military and veteran resources and referrals, including both VA and non-VA programs
- Identify any physical, medical and/or mental health issues related to service experience that will need further diagnostic work or treatment, or will impact treatment goals
- Explore areas of functioning in need of support as well as individual and family strengths, supports, and resources
- Address perceived barriers to seeking support and services

•Screening sources:

- https://askthequestionnh.com/providers/health-care/
- http://askthequestionnh.com/wp-content/uploads/PTS_TBI_MST_screenings.pdf

NETWORK 4 HEALTH

Domain 1 – Demographic / Race & Ethnicity :
Race & Ethnicity

Recommended screening:

1. **Are you Hispanic, Latino/a, or Spanish origin**

(one or more categories may be selected)
__a. No, not of Hispanic/Latino/a, or Spanish origin
__b. Yes, Mexican, Mexican American, Chicano/a
__c. Yes, Puerto Rican
__d. Yes, Cuban
__e. Yes, another Hispanic, Latino, or Spanish Origin

2. **What is your race?**
(One or more categories may be selected)
__a. White
__b. Black or African American
__c. American Indian or Alaska Native
__d. Asian Indian

__e. Chinese
__f. Filipino
__g. Japanese
__h. Korean
__i. Vietnamese
__j. Other Asian

__k. Native Hawaiian
__L. Guamanian or Chamorro
__m. Samoan
__n. Other Pacific Islander

•**Screening sources:**
•Uniform Data System (UDS) required reporting; https://bphc.hrsa.gov/datareporting/reporting/index.html
•Aligns with Behavioral Risk Factor Surveillance System (BRFSS), https://www.cdc.gov/brfss/index.html; and US DHHS Standards, https://aspe.hhs.gov/health-and-human-services-hhs-data-council

NETWORK 4 HEALTH

Domain 2 – Medical Conditions
Important to Include in Behavioral Health Settings

Recommended screening:

1. **Has a doctor, nurse or other healthcare provider ever told you that you have any of the following health concerns? Please select all that apply.**

__High Blood Pressure / hypertension

__High cholesterol / hyperlipidemia

__Diabetes / hyperglycemia

__Heart disease / cardiac problems

__Pediatric:

__Obesity

__Asthma

__Lead Poisoning

__None of these issues

Risk Designation: Individual is considered "at risk" with a positive response to any

Recommended Action: If yes, use interview to explore; asses if individual is receiving appropriate medical care to manage condition; refer to appropriate provider as indicated

Domain 3 - Substance Use Screenings (1 of 3)

18+ years old Screen

- **Recommend Screening(s):**
  - **18 and Older:**

NIDA *Quick Screen* Question: In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- **RISK Designation:**
  - Individual is considered at risk if they answer monthly, weekly or daily

Screening sources:

National Institute on Drug Abuse Quick Screen, https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen

NETWORK 4 HEALTH

Domain 3 - Substance Use Screenings (2 of 3)
12 - 18 years old Screen

Recommend Screening(s):

During the PAST 12 MONTHS, did you:

1. Drink any alcohol (more than a few sips)?

(Do not count sips of alcohol taken during family or religious events.)

Answer options: Yes or No check boxes

2. Smoke any marijuana or hashish?

Answer options: Yes or No check boxes

3. Use *anything else* to *get high?*

("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")

Answer options: Yes or No check boxes

4. In the past year, how often have you used Tobacco Products?

Answer options: Never, Once or Twice, Monthly, Weekly, Daily or Almost Daily

Risk Designation:

Questions 1-3 = any "Yes" answer

Question 4 = Individual is considered at risk if they answer monthly, weekly or daily

Screening sources:

CRAFFT Part A – alcohol and illicit drugs, http://www.ceasar-boston.org/CRAFFT/

NIDA – tobacco use, https://www.drugabuse.gov/publications/tobacco-nicotine-e-cigarettes/introduction

Domain 3 - Substance Use Screenings (3 of 3)

- **Recommended Action: Screening, Brief Intervention, Referral to Treatment (SBIRT-adult or youth, as appropriate)**
  - **Assess readiness for change (stage of change)**
  - **Provide stage specific interventions for SUD (pre-contemplation, contemplation, preparation, action, maintenance)**
    - Advise in clear, respectful terms to decrease or abstain from substance use
    - Encourage to:
      - set goals to align with stage of change and personal priorities
      - identify specific steps to reach those goals.
    - Teach behavior change skills that will reduce substance use and limit negative consequences.
    - Provide with a referral for further care, if needed

ALCOHOL	**Follow NIAAA Guidelines, one or more days of heavy drinking: at-risk drinker. See NIAAA website "How to Help individuals Who Drink Too Much: A Clinical Approach" for information on how to Assess, Advise, Assist, and Arrange help for at risk drinkers or individuals with alcohol use disorders**
TOBACCO	Any current tobacco use places a individual at risk. Advise all tobacco users to quit. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" (https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/index.html)
ILLEGAL OR PRESCRIPTION DRUGS FOR NONMEDICAL REASONS	begin the NIDA-Modified ASSIST. Provide feedback on the screening result; advise, assess & assist; utilize SBIRT as appropriate. Consider referral based on clinical judgment and arrange referral; offer continuing support

Screening Sources:

https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
https://www.integration.samhsa.gov/clinical-practice/sbirt/NIAAA_SBIRT_Pocket_Guide_-2-.pdf
https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/clinhlpsmkqt/index.html

NETWORK 4 HEALTH

Domain 4 - Housing & Transportation (1 of 2)

Housing Insecurity Screening

Recommend Screening:

1. **What is your housing situation today?**

__I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, in a park)

__I have housing today but I'm worried about losing housing in the future

__I have housing

Risk Designation: individual is considered "at risk" with response #1: I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, in a park)

Recommended Action: If yes, use interview to explore; asses cause of inadequate housing; assess/identify support systems that may be able to provide housing; refer to appropriate organization as indicated.

Screening sources:

CMS Screening for Health Related Social Needs in Clinical Settings, https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

NETWORK 4 HEALTH

Domain 4 - Housing & Transportation (2 of 2)

Transportation Screening

Recommend Screening:

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

__Yes

__No

Risk Designation: individual is considered "at risk" with response = Yes

Recommended Action: If yes, use interview to explore; assess support systems that may be able to provide transportation; refer to appropriate organization as indicated, e.g., NH Medicaid Coordinated Transportation Solutions (CTS), www.ctstransit.com; MCO approved transportation, public transportation subsidy, Step Savers

Notes

- The PRAPARE screening question has been modified to include "In the past 12 months" to provide reference timeframe for the individual.
- "In the past 12 months" is also used in the Transportation screening with the CMS Accountable Health Communities Screening Tool
- The response option "I choose not to answer this question" has been removed from the PRAPARE list of available responses. This is in line with the response options in the CMS Accountable Health Communities Screening Tool
- Only 1 Yes response option will be included, in line with the Health Leads screening question recommended by the NH State workgroup

Screening sources:

PRAPARE: http://www.nachc.org/research-and-data/prapare/
CMS Accountable Health Communities Screening Tool: https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf
Health Leads: https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-July-2016.pdf

NETWORK 4 HEALTH

Domain 5 - Family & Supportive Services (1 of 2)

Social Isolation

Recommend Screening:

1. How often do you see or talk to people that you care about and feel close to?

__Less than once a week

__1 or 2 times a week

__3 to 5 times a week

__More than 5 times a week

2. How often do you feel isolated from others?

Response options:

__1. Hardly ever

__2. Some of the time

__3. Often

Risk Designation: Question 1 = Less than once a week **and / or** Question 2 = answer # 3, Often

Recommended Action: Use interview to explore, assess and identify support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client choice, including "2-1-1 NH," a program of Granite United Way, http://www.211nh.org/

Screening sources:

Question 1: PRAPARE EHR Screening, http://www.nachc.org/research-and-data/prapare/
http://www.nachc.org/wp-content/uploads/2016/07/PRAPARE-Epic-Training.pdf
Question 2: Hughes 3 Item Loneliness Scale, Question #3, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2394670/
https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf
http://www.211nh.org/

NETWORK 4 HEALTH

Domain 5 - Family & Supportive Services (2 of 2)
Intimate Partner Domestic Violence /Safety

Recommend Screening:

1. Do you feel safe at home?

__Yes

__No

2.How often do you feel physically or emotionally threatened by a partner or other family member?

Response options:

__1. Never

__2. Rarely

__3. Sometimes

__4. Frequently

Risk Designation: Considered at risk if "No" to Question 1, or "Sometimes" or "Frequently" to Question 2

Recommended Action: Must be in compliance with reporting policies, rules, and laws. Use interview to explore, assess with more thorough screening tool as per your organization's policy. US Preventative Services Task Force (USPSTF) suggested effective assessment tools include: Humiliation, Afraid, Rape, Kick (HARK); Hurt/Insult/Threaten/Scream (HITS); Extended Hurt/Insult/Threaten/Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST). Identify support systems; peer support, community organizations, faith based supports; refer to appropriate organization as indicated by client choice and as per reporting guidelines. According to USPSTF: 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.

Screening sources:

https://www.uspreventiveservicestaskforce.org

NETWORK 4 HEALTH

Domain 6 - Education/Health Literacy (1 of 2)

Recommend Screenings:

1. **What is the highest level of school you have finished?**

   __Less than a high school degree, still in school

   __Less than a high school degree, not in school

   __High school diploma or GED

   __More than high school

2. **How confident are you filling out forms by yourself***

   (*this question is asked prior to administering CCSA)

   __1. Not at all

   __2. A little bit

   __3. Somewhat

   __4. Quite a bit

   __5. Extremely

Risk Designation: individual is considered "at risk" with responses 1(Not at all) and 2 (a Little Bit)

Domain 6 - Education/Health Literacy (2 of 2)

Recommended Action: Use health literacy tools like teach back (http://www.teachbacktraining.org) ; user reader-friendly materials using "plain language" communication and design principles (https://www.plainlanguage.gov). Use interview to explore; assess needs and literacy support systems; refer to appropriate organization as indicated,.

Notes: Modifications for IDN 4 use:

- The response option "I choose not to answer this question" has been removed from the PRAPARE list of available responses for the Education question.
- Question 1 response, "Less than a high school degree" has been broken into 2 responses to account for the screening question being applied to individuals 12+
- IDN 4 is utilizing only one of the four BRIEF health literacy screening questions.
- The BRIEF health literacy screening question has been modified from: How confident are you filling out medical forms by yourself? This is due to its use across mental health, substance use disorder, primary care and social services agencies across the IDN.

•**Screening Sources:**

•Health Literacy Question: BRIEF health literacy screening: Haun, J., Luther, S., Dodd, V., & Donaldson, P. (2012). Measurement variation across health literacy assessments: implications for assessment selection in research and practice. J Health Commu,17 Suppl 3:141-59. doi: 10.1080/10810730.2012.712615.\

•http://www.teachbacktraining.org

•https://www.plainlanguage.gov

•Education Question: PRAPARE- http://www.nachc.org/research-and-data/prapare/

•Uniform Data System (UDS) , http://www.bphcdata.net

•Generally aligns with NH DHHS Office of Health Equity

Domain 7 - Employment & Entitlement (1 of 3)

Financial Strain

Recommend Screening:

1. In the past 12 months, how hard is it for you to pay for the very basics like health insurance, food, housing, medical care and/or medications?

   __1. Not at all

   __2. Somewhat Hard

   __3. Very Hard

2. **If response is "somewhat" or "very hard", ask :** "What do you have trouble paying for?"

Risk Designation: individual is considered "at risk" with responses 2 (Somewhat Hard) and 3 (Very Hard)

Recommended Action: follow-up assessment IF risk designation met:

- Assessment Source: PRAPARE
- Check all that apply

  Food: __Yes __No

  Utilities: __Yes __No

  Clothing: __Yes __No

  Child Care: __Yes __No

  Phone: __Yes __No

  Medicine or any health care (medical, dental, mental health, vision): __Yes __No

  Other: (Please Write)

Use interview to explore; assess/identify support systems; refer to appropriate organization as indicated

Domain 7 - Employment & Entitlement (2 of 3)

Financial Strain

Refer to appropriate organization as indicated (continued):

- Statewide resource guide (housing, legal, etc): https://www.nhcarepath.dhhs.nh.gov/partner-resources/documents/community-support-housing-resource.pdf
- IDN 4 Continuum of Care Resources
  - Manchester Continuum of Care resource guide, https://mcocnh.org/wp-content/uploads/2018/02/MCoC-Resource-Guide.pdf,
  - South Central resource guide , http://southcentralphn.org
- Statewide SUD Treatment: https://www.dhhs.nh.gov/dcbcs/bdas/documents/resource-guide-treatment.pdf
- For Older Adults: http://caringcompanionsnh.com/wp-content/uploads/2016-Seniors-Count-Resource-Guide.pdf

Notes:

- Add “in the past 12 months” to provide context, in alignment with PRAPARE screening question.
- Add “health insurance” to the list of examples in alignment with PRAPARE screening question

Screening sources:

Kaiser Permanente, https://kaiserpermanente.org
Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE), http://www.nachc.org/research-and-data/prapare

NETWORK 4 HEALTH

Domain 7 - Employment & Entitlement (3 of 3)

Lack of Employment Screening

Recommend Screening(s):

What is your current work situation?

__Unemployed and seeking work

__Part time or temporary work

__Full time work

__Otherwise unemployed but not seeking work (ex. Student, retired, disabled, unpaid primary care giver). Please write: _____

Risk Designation: individual is considered "at risk" with response: Unemployed and seeking work

Recommended Action: Recommended follow-up assessment IF risk designation met: PRAPARE tool

Optional Feature—Additional Response:

__Work less than 20 hours a week

__Work 20-34 hours a week

__Work 35-59 hours a week

__Work 60 yours or more a week

Optional Feature—Additional Question

How many jobs do you work?

__1 job

__2 jobs

__3 or more jobs

__I choose not to answer this question

- If unemployed, use interview to explore; assess/identify support systems; 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

Notes: The response option "I choose not to answer this question" has been removed from the PRAPARE list of available responses.

Screening sources:

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), http://www.nachc.org/research-and-data/prapare

NETWORK 4 HEALTH

Domain 8 - Legal Issues

- **Recommend Screening(s):**

  Do you have any past or current legal issues that are getting in the way of your health or well being.

  __Yes

  __No

- **Risk Designation**
- individual is considered "at risk" with response: Yes
- **Recommended Action:** Use interview to explore; assess/identify support systems; refer to appropriate resources/organization as indicated; e.g. NH Legal Aid, http://www.nhlegalaid.org
- **Screening sources:**
  - Recommendation from NH DSRIP Integrated Care workgroup
- **Notes:**
  - Modification from original recommended DHHS wording of "Do you have any legal issue…"

Domain 9 - Suicide Risk

Depression and Suicide

Recommend Screening incorporates PHQ 2 AND Question 9 of the PHQ 9:

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Risk Designation: Utilize scoring per PHQ-3 and PHQ-9

Recommended Follow-up Assessment for positive screens: Full PHQ-9 , **refer anyone with moderate depression or higher or scores 1, 2, or 3 on question #9 for immediate BH assessment**

Screening sources:

- individual Health Questionnaire- 2, Pfizer, Inc. http://www.cqaimh.org/pdf/tool_phq2.pdf
- individual Health Questionnaire- 9, Question 3 ONLY - Pfizer, Inc. http://www.cqaimh.org/pdf/tool_phq9.pdf
- in alignment with Zero Suicide screening approaches

Domain 10 - Functional Status (1 of 3)

ADL

Recommend Screening(s):

Do you need assistance to complete any of the following?

__ Get out of bed

__ Get Dressed

__Climbing Stairs

__ Walking

__Shop for Personal Needs

__Prepare Meals

__Use Telephone

__Take your Medications as prescribed

__Managing money

Risk Designation: individual is considered "at risk" if answer is yes to any.

Recommended Action: Provider , as appropriate, refers Pt to PCP for age/developmental ADL/iADL assessment, identifying PCP and scheduling appointment while Pt in office, ensure closed-loop referral. PCP provider completes age/developmental ADL/iADL assessment; makes referral to appropriate provider as indicated

Screening sources:

Based on ADL and iADL categories

Question wording modified from AHRQ https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/health-assessments/healthassessment-adl4.html

Domain 10 - Functional Status (2 of 3)
iADL

Recommend Screening(s):

Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?

___Yes

___No

Risk Designation:

- individual is considered "at risk" if answer is yes to any.

Recommended Action: Provider, as appropriate, refers Pt to PCP for age/developmental ADL/iADL assessment, identifying PCP and scheduling appointment while Pt in office, ensure closed-loop referral. PCP provider completes age/developmental ADL/iADL assessment; makes referral to appropriate provider as indicated

Screening sources:
Network4Health CCSA Workgroup recommendation

NETWORK 4 HEALTH

Domain 10 - Functional Status (3 of 3)

- **Recommend Screening(s):**

  Have you fallen in the last year?

  ___Yes

  ___No

  Do you ever feel unsteady when standing or walking?

  ___Yes

  ___No

- **Risk Designation:**
  - individual is considered “at risk” if answer is yes to any.

Recommended Action: Provider, as appropriate, refers Pt to PCP for complete cognitive assessment, identifying PCP and scheduling appointment while Pt in office, ensure closed-loop referral. PCP completes age appropriate cognitive assessment

Screening sources:

•Center for Disease Control and Prevention, https://www.cdc.gov/steadi/index.html

NETWORK 4 HEALTH

Developmental & Behavioral Health Screenings
Pediatric Population

Recommend Screening(s):

Do you have any concerns related to your child's development in the following areas?

__Gross Motor Skills (larger movements your child makes with his arms, legs, feet, or his entire body like crawling, running, and jumping

__Fine Motor Skills (smaller actions your child performs using fingers and toes or facial expression)

__ Communication and speech

__ Social behavior

Risk Designation:

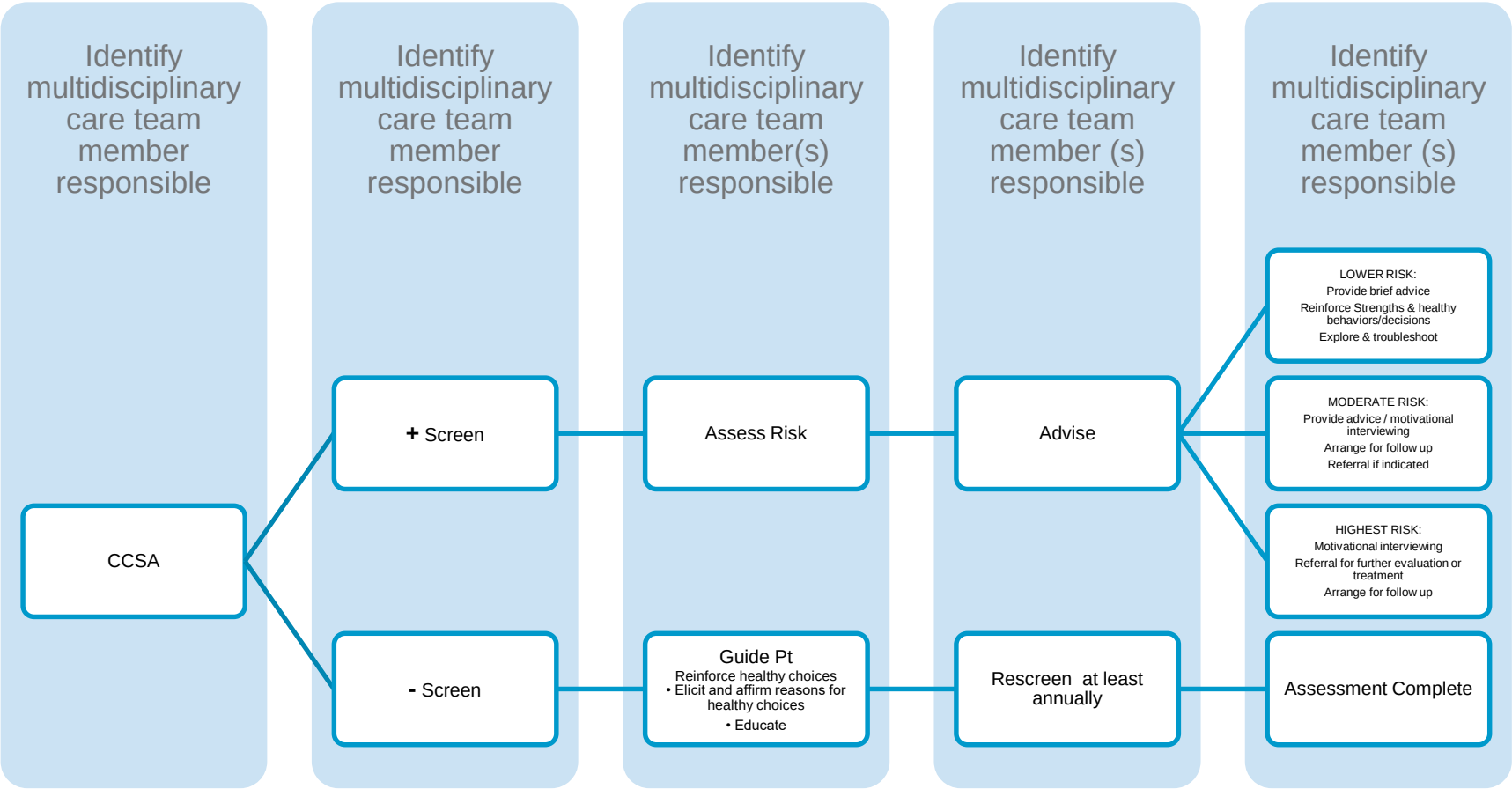
- individual is considered “at risk” if answer is yes to any.

Recommended Action: Provider, as appropriate, refers Pt to PCP for complete developmental screening, identifying PCP and scheduling appointment while Pt in office, ensure closed-loop referral. PCP completes age appropriate developmental assessment

Screening sources:
N4H CCSA Workgroup recommendation N4H CCSA Workgroup recommendation

NETWORK 4 HEALTH

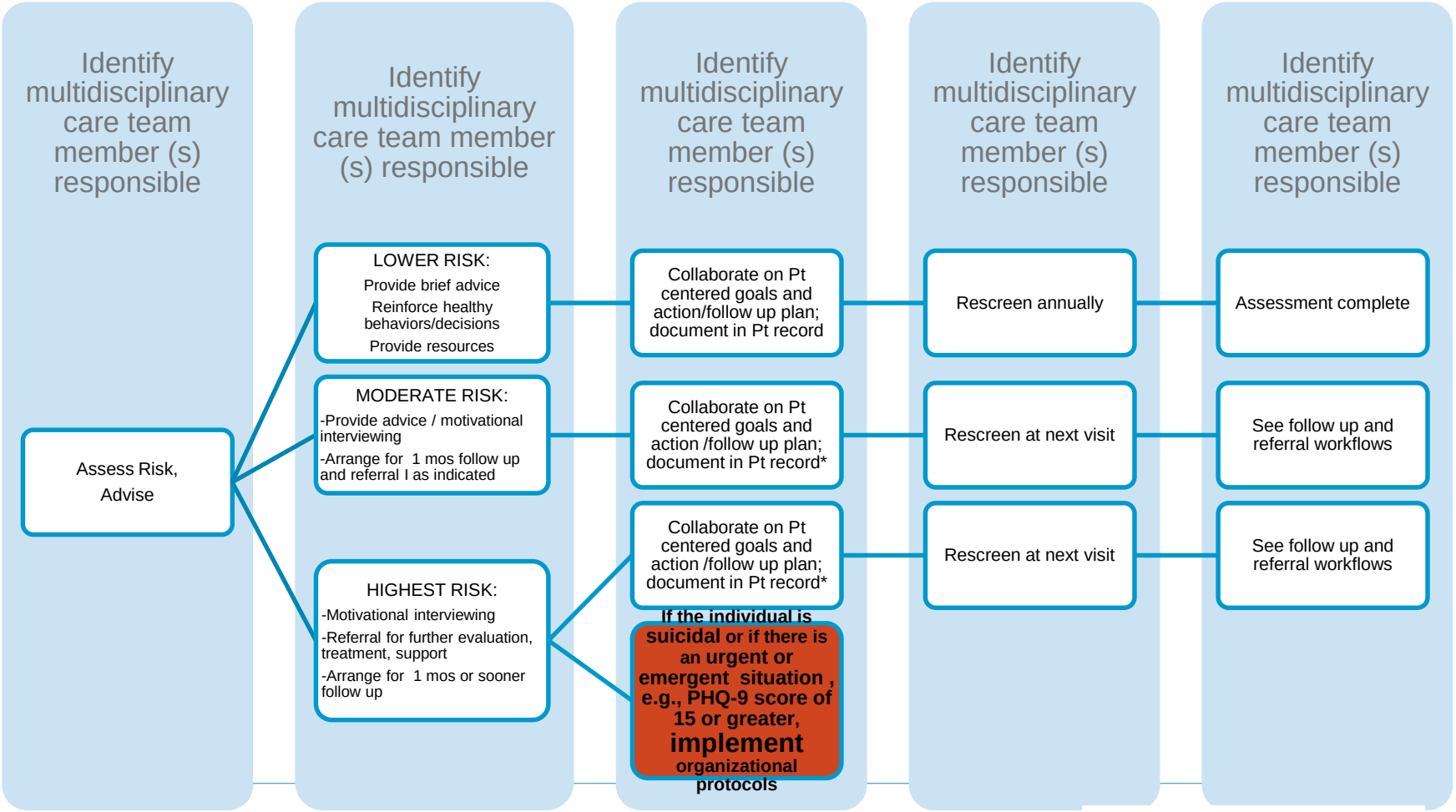
CCSA Screen Workflow



Source: https://www.integration.samhsa.gov/clinical-practice

+ CCSA Screen

**in red box add score 1,2,3 on question 9

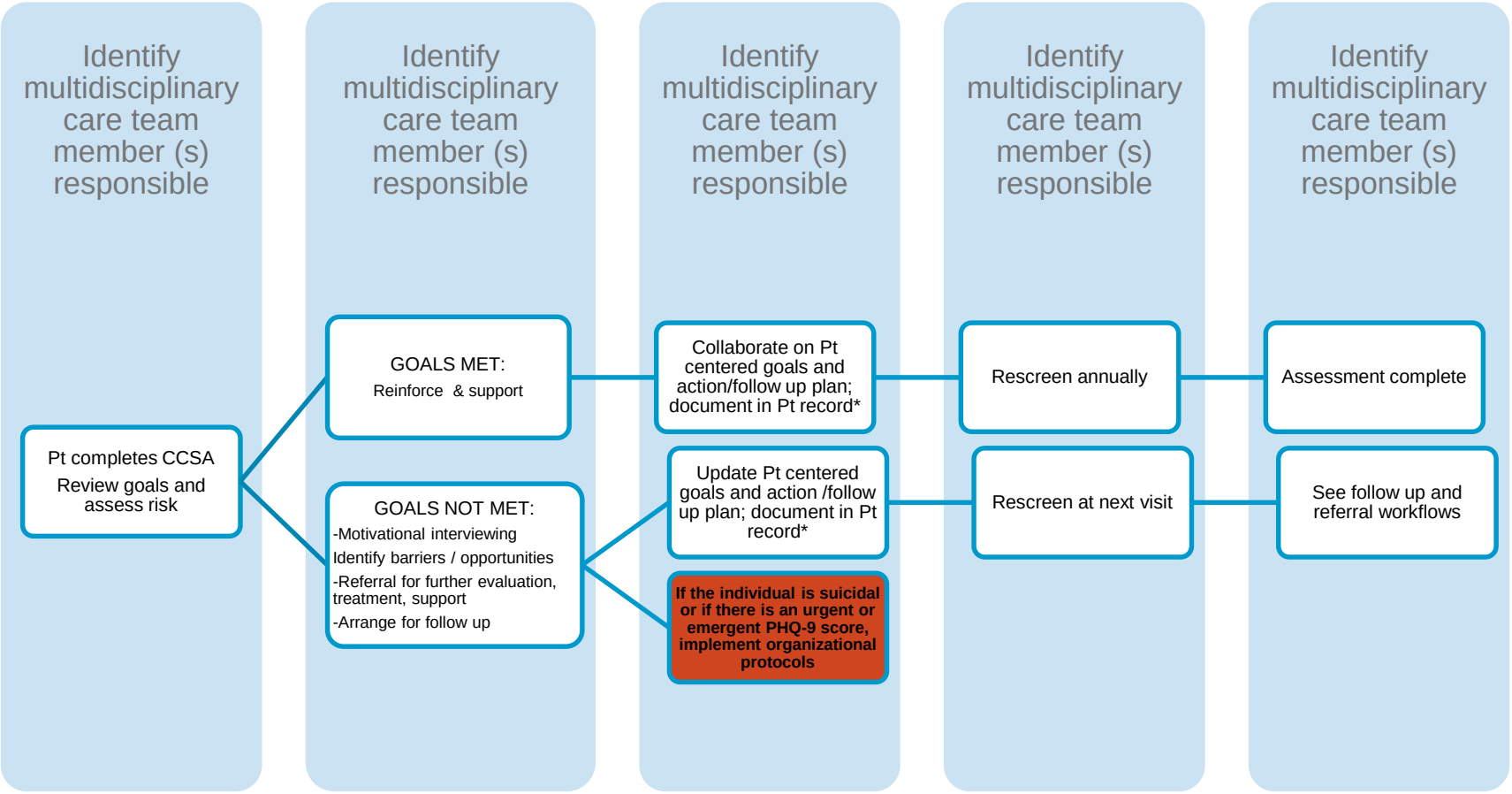


* Required for SUD and + depression screens)

NETWORK 4 HEALTH

Source: https://www.integration.samhsa.gov/clinical-practice

+ CCSA Screen Follow Up Workflow

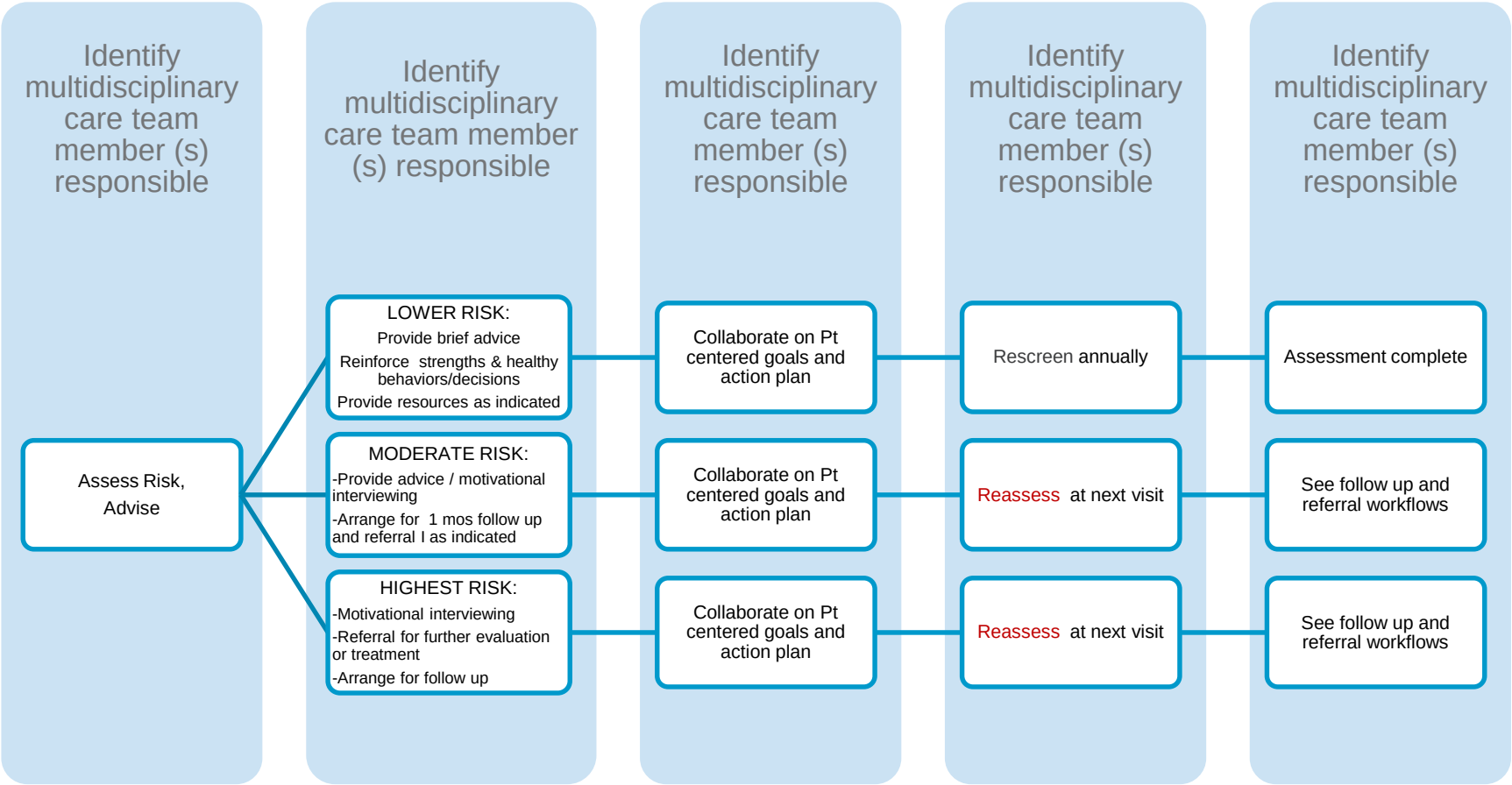


* Required for SUD and + depression screens)

NETWORK 4 HEALTH

Source: https://www.integration.samhsa.gov/clinical-practice

+ CCSA Screen Referral Workflow



* Required for SUD and + depression screens)

NETWORK 4 HEALTH

Source: https://www.integration.samhsa.gov/clinical-practice

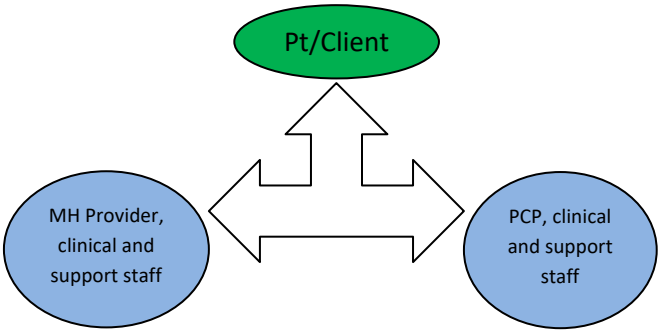
Integrating Mental Health and Primary Care – Multi-disciplinary Teams and the Closed Loop Referrals

Recommended Best Practices

"Integrated behavioral health and primary care is anchored in inter-professional practice. The clinician does not work independently but rather contributes to a dynamic in which the "whole of the team" is greater than the sum of its parts (e.g., individual team members). Characteristics of effective clinical teams include an understanding of roles, responsibilities, values, and ethics for inter-professional practice and communication." - Agency for Health Research and Quality (AHRQ)

Core Components

1. **Multi-Disciplinary core teams and Referrals**- Assure full engagement of the patient/client, dyad physicians (primary care and mental health providers), management, and referral staff. (See Appendixes A, B, C & D)



According to AHRQ's Academy Integrating Behavioral Health and Primary Care, these multi-disciplinary or inter-professional teams involve "medical and behavioral health clinicians [who] collaborate with each other and with patients and families to address health concerns identified during… visits… Behavioral health clinicians often work right in the medical setting, or, if not onsite, are thoroughly integrated into the established procedures, team, and information systems." Interdisciplinary team meetings create awareness among clinicians from different backgrounds that help them develop and understand each other's work and services … Interdisciplinary team meetings and conversations afford opportunities for more in-depth dialogue to develop care plans for very complex patients."

2. **Formal Co-created PCP- MH Provider Shared Care Compact / Memorandum of Understanding (MOU)** to be completed in writing prior to the start of the collaborative to gain agreement regarding referral types and definitions, role expectations, and communication expectations. (See Appendix E)

3. **Structured reports**, to be simple but meaningful for both sides. (See Appendix F)
4. **Valuable measures** - Clarify measure definitions and share individual/aggregate data early and spread quickly.

Appendix A

Guidelines to build a Multi-disciplinary core team (adapted from SAMHSA/Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit, https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf)

1. Define Goals and develop a shared aim collaboratively between primary care and mental health care. Create a sense that these are **our** patients

Examples:

- Improvement of patient's and community's health based through evidence-based practice
- Improvement in access to care
- Improvement in service to patients
- Provider and staff satisfaction and joy in work
- Improvement in practice's financial performance

2. Define specific, measurable outcomes and objectives. Align with your other initiatives and metric reporting

Examples:

- At least 90% of patients with diabetes will have > 2 HgbA1c per 12 months
- Members of the assigned team will attend at least 80% of scheduled team meetings

3. Assign roles for each team member and define and delegate functions and tasks

- Determine which people on the team are best qualified to perform the tasks within the clinical and administrative systems of the practice (efficiency)
- Introduce team members so they know who each other are
- Introduce each members role (skills) so members on the team know what each other does and can do in their role
- Maximize the role of each team member within the scope of their licensure and skills, "working to the top of the license."
- Ensure that the right person is doing the right task for the right patient at the right time (is the team efficient in their workflow?)
- Ensure that each team member is competent to perform their defined and delegated functions and tasks
- Provide education and training for the functions and tasks that each team member performs
- Provide adequate IT training. Include electronic health record (EHR), secure messaging / email, closed loop referral system, intranet.
- Provide education and cross-training to substitute for other roles (in cases of absences, vacations, or periodic heavy demands on one part of the team)

- Provide all team members with communication training for effective teamwork, for example, motivational interviewing
- Assess competency of team members at least once each year (performance review) and have team members set goals which contribute to team performance
    - Communicate each member's competencies to the other team members!

5. Ensure that clinical and administrative systems support team members in their defined work

Examples:

- Procedures for providing prescription refills
- Procedures for informing patients of laboratory results
- Procedures for making patient appointments
- Policies on how decisions are made in the practice
- Work schedules allow time for team members to perform all parts of their job
- Adequate level of permissions in EHR which allow teams to perform
- Create communication structures and processes – a communication plan is helpful

  Examples:

    - Schedule team meetings and/or "huddles"
    - Hold team members accountable for attending and participating in team meetings and
    - "huddles"
    - Clearly communicate expectations, assignments, tasks, roles to all team members
    - In between team meetings, routinely communicate through electronic information. These communications will help team members know the work is getting done.
    - In between meetings, share important information through brief verbal interactions among team members
    - Provide feedback to care team members on a daily basis re: work well done and opportunities for improvement
    - Decide on a process for conflict resolution among team members and implement the process

7. 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?

Teamwork takes practice. Share your learning with other care teams at your site, organization and other organizations in the integrated delivery network (IDN).

Considerations in Forming Teams

How many teams should be organized at a site? One per panel.

HINT: Let the number of PATIENTS per team be your guide……..

- Consider Planned Care Teams as the smallest number of people who can accountably be responsible for achieving the population health outcomes for patients.

- Consider forming coverage teams as pairs or clusters of providers and staff who can cover for each other during planned and unplanned absences. This can help the covering teams know the patients.
- Each care team at a particular site should have a balanced patient population in order to balance the workload
- Some teams have organized around a language of a patient population, especially if team members speak that particular language.
- A pharmacist, RN, MA, Front Desk, RD, SW, etc. may be on more that one team depending on the number of staff at a site
- One team may have more than one RN, MA, Front Desk, RD, SW, etc. depending on the number of staff at a site.
- HINT: Assign everyone at your site to a team!
- Schedules of team members may influence who is on the team. In order to facilitate communication, consider overlap of schedules among team members
- Literature suggests that < six team members is the optimal size and teams with greater that twelve members are too large.

HINT: If the team is too large:

- There may be too many hand-offs which can increase the risk of errors (of omission)
- Communication among larger teams may require more effort

HINT: if the team is too small:

- There may be staff who touch the patient who are not included in the team's
- planning, communication, or work effort leading to redundancies, inefficiencies, and missed opportunities

How is the work of a Care Team Organized?

The work of care teams to deliver proactive, population-based, patient-centered primary care is divided into 3

domains of work: pre-visit, visit, and between visit work.

Appendix B: Referral Forms Templates

CCNC, in partnership with other stakeholders, has developed a set of three referral forms for primary care and behavioral health providers to facilitate easier consultation and communication… A summary of revisions to the forms is available **here** and instructions for using the forms are available **here**.

Form #1 – Behavioral Health Request for Information is for behavioral health providers who begin working with a new consumer or identify a potential medical need, and wish to make contact with the primary care provider (PCP).

Form #2 – Referral to Behavioral Health Services Section I is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.

Form #3 – Behavioral Health Feedback to Primary Care Section II is to be used in conjunction with the second form listed above. It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

https://www.communitycarenc.org/what-we-do/clinical-programs/behavioral-health-integration/referral-forms

Appendix C: Referrals & Warm Handoffs

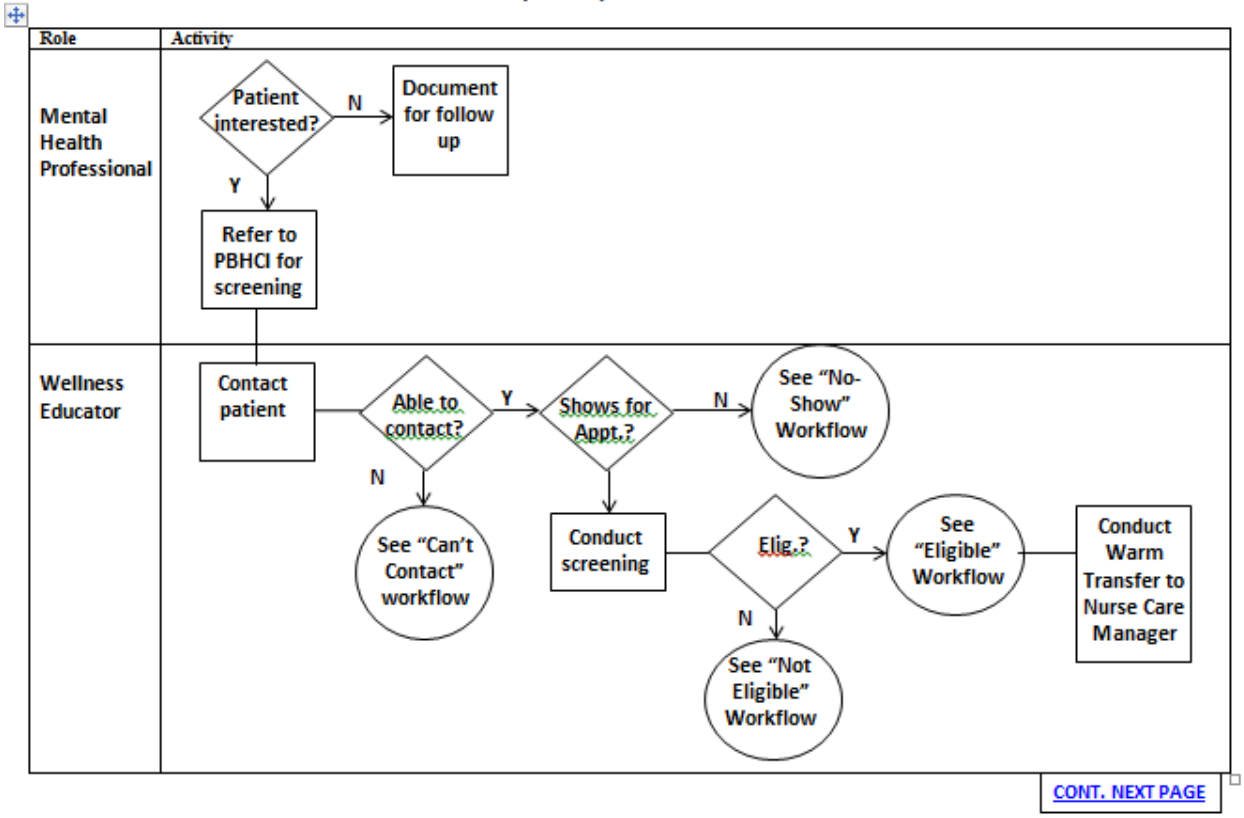
- From Primary Care to Behavioral Health: Warm Handoff Scripts and Procedures (.doc)
- From Behavioral Health to Primary Care: Warm Handoff Scripts (.doc)
- From Other Staff/Departments: Five Scripts For Great Handoffs (.doc)
- Handoff Self-Check (.doc)

Good-byes

- Provider Goodbye Tips for the End of the Patient Visit (.doc)
- Great Goodbyes Self-Check(.doc)

Appendix D: Sample Workflows & Templates

ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER



ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER

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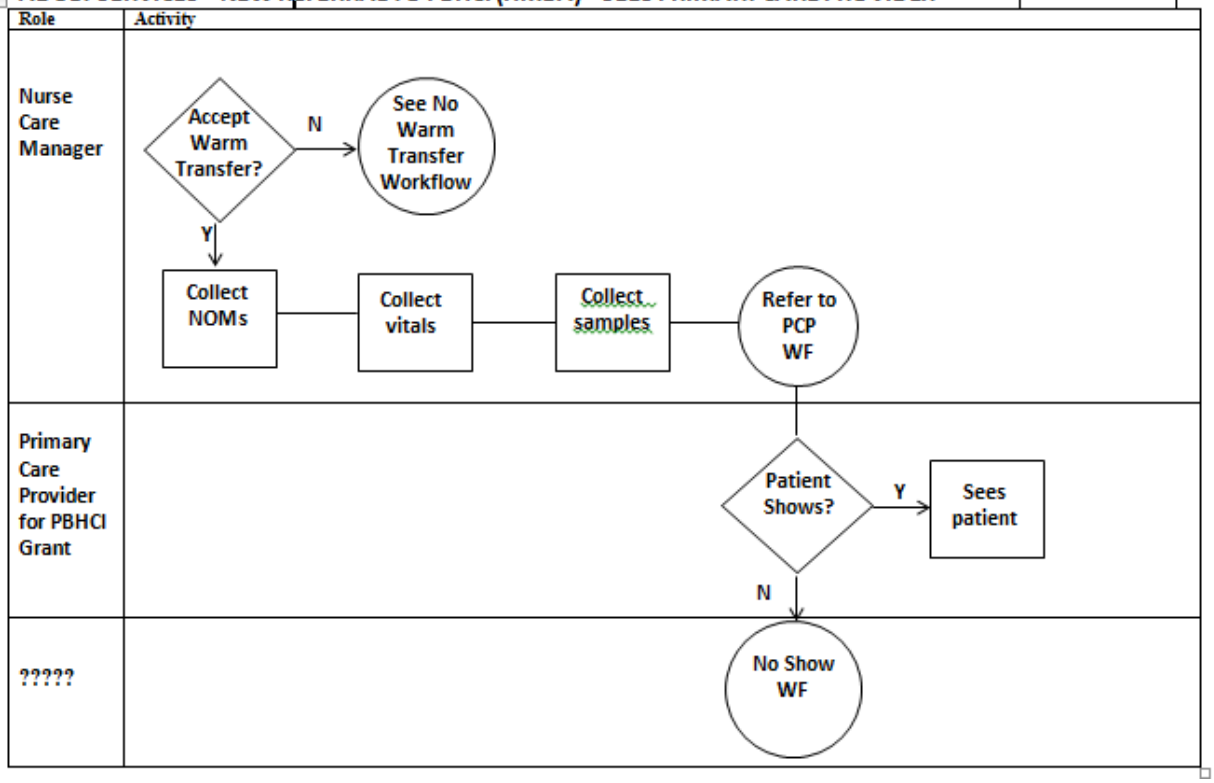
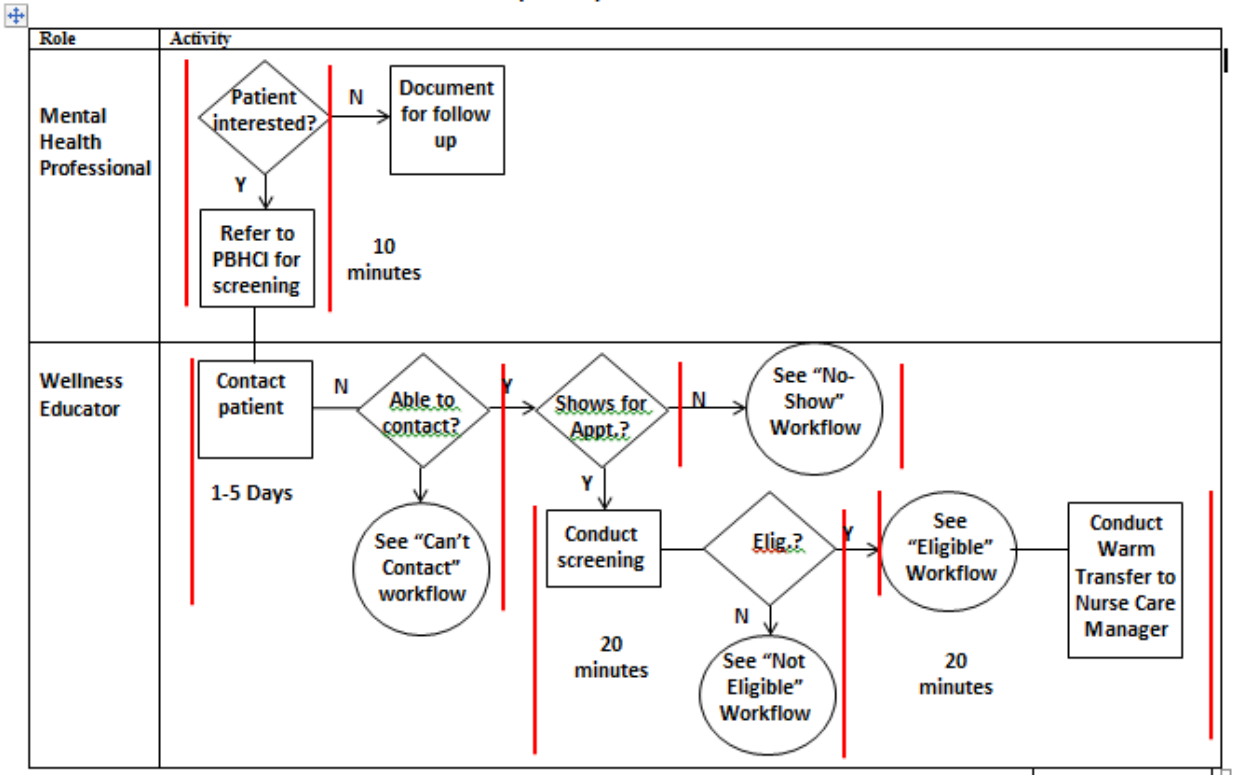


ADULT SERVICES > NEW REFERRAL TO PBHCI (HMBA) > SEES PRIMARY CARE PROVIDER



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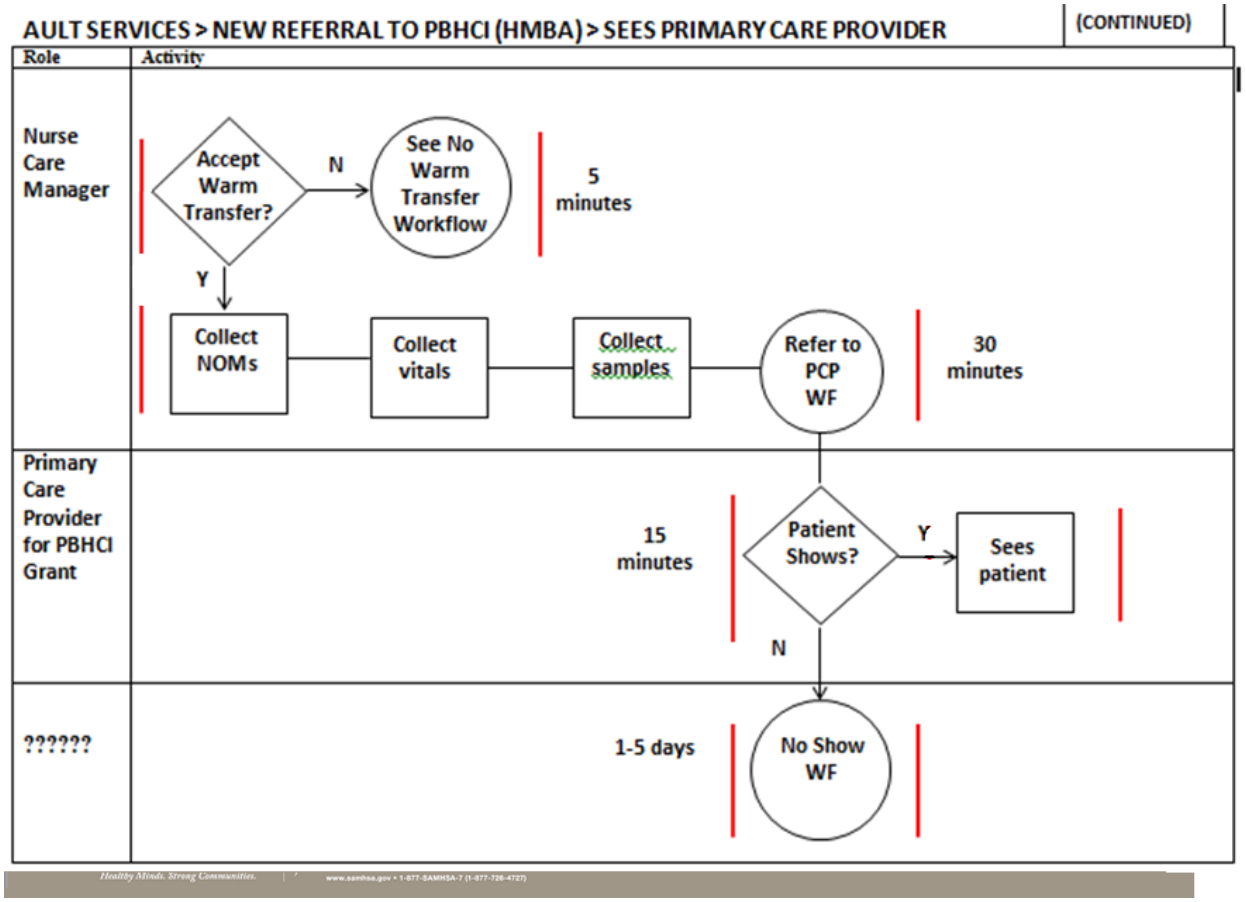


Templates to create workflow diagram and business process analysis

See SAMHSA Business Process Analysis Workbook;
https://www.integration.samhsa.gov/search?q=closed+loop+referral

Appendix E: Co-created PCP- MH Provider Shared Care Compact **Sample Collaborative Care Compact**

The primary care practice of _____ and the mental health practice of _____ have developed a Collaborative Care Agreement. This agreement is based on the following agreed upon collaborative care guidelines.

Collaborative Guidelines

Aim Statement: Our aim is to improve the coordination of patient/client care between our offices. Specifically, we aim to ensure:

1) Patients/clients are seen in an appropriate time frame;

2) Clinical questions and responses are clearly stated and effectively communicated from one office to another;

3) Patients/clients understand the reason for their referral and are satisfied with the referral process.

Principles

• Safe, effective and timely patient/client care is the central goal.

• Effective communication between mental health and primary care providers is key to providing optimal integrated care.

• Mutual respect is essential to building and sustaining a professional relationship and working collaboration.

• A high functioning integrated health system of care provides patients/clients with access to the 'right

care at the right time in the right place.'

Referral Definitions:

• **Time Stratified Referrals**

- **Urgent Referral** – referrals that require the patient/client to be seen immediately (the verbal or written handoff is the referral and once completed the referral is considered to be closed).
- **Priority Referral** – referrals that require the patient/client to be seen by the mental health provider within 14 days.
- **Priority Patient/Client Preference Referrals** – referrals with appointments that are not in the specified time period due to patient preference.
- **Routine Referral** – referrals that require the patient/client to be seen by the provider within 28 days.
- **Routine Patient/Client Preference Referrals** – referrals with appointments that are not in the specified time period due to patient preference.

Prepared Patient/Client – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision-making and self-management.

• **Referral Specialist** – a team member in the office who is responsible for receiving the referral request, overseeing the referral process in the office, and sending the referral document with the clinical question to the primary care or mental health provider, as appropriate.

Appendix F: Referral Summary of Care Record

• Referral - A new patient is referred between primary and mental health care providers. Provider sends Summary of Care Record with Referral that includes:

- Plan of Care field (Patient/client centered goals and instructions)
- Care team (other providers)
- Reason for Referral – Clinical Issue/Information

o Current problem list

- Current medication list
- Current allergy list

• Referral Type - Based on urgency of care required, PCP marks the referral as:

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

- Appointment Scheduling – The patient/client is scheduled for an appointment with the office schedules per type of referral and patient/client preference.
- **Closing the Loop** – Once the patient/client is seen by the provider referred to, the provider sends the visit note to the referring provider with the clinical issue answered within one week of the appointment.
  - **No Shows** – If the patient/client doesn't show up as per the scheduled appointment, the provider referred to marks it as one of the following and sends it back to the referring provider:

    ▪ No Show – Priority Referral

    ▪ No Show – Routine Referral

  - **Delayed referral timing due to**:

    ▪ Delayed Priority Referral – Patient/client preference

    ▪ Delayed Routine Referral – Patient/client preference

Mutual Agreement for Referral Management

• Review the level of care tables and determine which services you can provide.

• The Mutual Agreement section of the tables reflects the core element of integrated care (aligning with PCMH) and outline expectations from both primary care and mental health care providers.

• The Expectations section of the tables provides flexibility to choose what services can be provided depending on the nature of your practice and working arrangement.

• The Additional Agreements/Edits section provides an area to add, delete, or modify expectations.

• After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.

• When patients/clients self-refer to primary care or mental health provider, processes should be in place to determine the patient's overall needs and reintegrate further care with the primary care or mental health provider, as appropriate.

• The agreement is waived during emergency care or other circumstances that preclude following these elements necessary to provide timely and necessary medical care to the patient/client.

• Each provider should agree to open dialogue to discuss and correct real or perceived

breaches of this agreement, as well as, on the format and venue of this discussion.

• **Optimally, this agreement should be reviewed every year.**

https://c.ymcdn.com/sites/www.thepcpi.org/resource/resmgr/Final-CRL-Toolkit-6-19-17.pdf

REFERENCES

Agency for Healthcare Research and Quality (AHRQ); http://integrationacademy.ahrq.gov/about/what-integrated-behavioral-health

Closing the Referral Loop: Improving Communication and Referral Management; http://app.ihi.org/FacultyDocuments/Events/Event-2930/Presentation-15886/Document-13144/Presentation_C6_ClosingtheReferral_Sheth.pdf

Community Care of North Carolina; https://www.communitycarenc.org/what-we-do/clinical-programs/behavioral-health-integration/referral-forms

Integrated Behavioral Health Partners; http://www.ibhpartners.org/?section=pages&cid=123

SAMHSA Business Process Analysis Workbook; https://www.integration.samhsa.gov/search?q=closed+loop+referral

SAMHSA Core Competencies for Integrated Behavioral Health and Primary Care; https://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf

SAMHSA Essential elements of Effective Integrated Primary Care and Behavioral Health Teams; https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/essential-elements-integrated-teams.pdf

SAMHSA Team Based Care Implementation; https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf

Project C1: Critical Time Intervention

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDNs were required to complete an IDN Community Project Implementation Plan including design and development of clinical services infrastructure plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

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

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

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

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

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables C-2 through C-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Network4Health's Critical Time Intervention (CTI) program is fully implemented. As of June 2018, we are serving 33 clients based off of 67 referrals. Although no clients have completed the program at this time, all clients actively enrolled in the program are moving through the phases of CTI in accordance with fidelity standards of the Critical Time Intervention model. All clients have phase plans in place and Transition Coaches are completing phase plan reviews at the 90, 180, and 270 day marking period. All clients enrolled in CTI program have completed the Illness Management & Recovery Scale upon admission. Although the 5 IDNs implementing CTI tried to come to consensus on the use of a recovery assessment and client satisfaction tools, this did not occur due to the unique timing of each region's implementation.

Through CTI, Network4Health has provided barrier reduction funds to support clients in obtaining proofs of identification, such as photo id, birth certificates, and social security cards. These have been instrumental in assisting clients applying for benefits as part of their transition plan.

Network4Health and its partners held several trainings for the CTI project during this reporting period. The Care Transitions Clinical Director ([redacted]), Care Transition Coaches ([redacted], [redacted], [redacted], [redacted]) and our C1 Administrative Assistant ([redacted]) all attended training, including:

- Active Shooter Training (1/17/18): attendees included [redacted], [redacted], [redacted] [redacted], [redacted], [redacted]
- Cultural Competency training (1/29/18): attendees included [redacted], [redacted], and [redacted]
- DBT Skills for non-DBT practitioners (2/15 & 2/16/18): attendee - [redacted]
- LEAP Training (2/20/18): attendees included [redacted], [redacted]
- Stigma (Internal MHCGM required training) (2/22/18): attendee - [redacted]
- Overcoming Stigma (3/1/18); attendees included [redacted], [redacted]
- Cognitive Behavioral Therapy (CBT) (3/13/18): attendees included [redacted]. [redacted] [redacted]
- Critical Time Intervention (3/19 & 3/20/18): attendees included [redacted], [redacted], [redacted], [redacted] and [redacted]
- Motivational Interviewing 2 (3/22/18): attendees included [redacted], [redacted]
- Treating Mental Health in People w/Criminal Background (3/28/18): attendee - [redacted]
- Ethics (4/10/18): attendee - [redacted]
- Initial Training on Addiction (5/10/18): attendees included [redacted], [redacted] and [redacted]
- Connect Suicide Prevention (non-clinical) (5/22/18): attendee- [redacted]
- Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention (6/11/18): attendees included [redacted], [redacted] and [redacted]
- Criminal Thinking & Antisocial Logic (6/27/18): attendees included [redacted], [redacted] [redacted]

Our updated project plan is attached as Attachment_C1.1.

C-2. IDN Community Project: Evaluation Project Targets

From the Evaluation Project Plan, use the format below to provide a list of the progress toward targets or goals that the program has achieved. Targets required by the STCs, include but should not be limited to:

- *Number of individuals served (during reporting period and cumulative)*
- *All performance measures identified in the evaluation project plan.*

Network4Health has included an additional performance measure for the number of referrals received to reflect community engagement. Referrals are reviewed as a team and are assessed by a coach to determine eligibility. During assessment, clients are provided materials detailing CTI program specifics and phases and a given the opportunity to consent or decline. Some clients require multiple visits prior to making a decision about their willingness to participate in the CTI program.

The focus for this reporting period was to set targets for performance measures. Based on these performance measure targets, we have worked closely with the MHCGM to develop reports in the EMR that will provide data on these measures. These reports are not yet finalized although significant

progress has been made and we anticipate having finalized reports prior to the January 2019 SAR. For reporting purposes, the performance measures have been adjusted to reflect averages.

It is our expectation that the number of MH & SUD visits will increase as clients move through phases demonstrating more consistency and stronger connections with providers. It is difficult to predict an average number of appointments as each client's treatment plan will look different and each client has unique needs. As we begin to receive data there is the potential these targets will need to be revised.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Number of individuals served anytime in program	Up to 333	1	33	
Number of individuals referred to program	Up to 333	1	67	
Number of individuals completed program	Up to 333	0	0	
Average # days from transition to first BH outpatient visit	Up to 20 days			
Average # of mental health and substance abuse visits at end of Phase 1	Up to 4			
Average # of mental health and SUD visits at end of Phase 2	Up to 6			
Average # of mental health and substance abuse visits at end of Phase 3	Up to 8			
Increase average # of community resource contacts from program enrollment to program completion	Up to 5			

C-3. IDN Community Project: Workforce Staffing

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

Care Transitions experienced turnover of one CTI Coach during this reporting period and hired an additional two CTI Coaches. We are still actively recruiting for a sixth CTI coach.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Critical Time Intervention (CTI) Director/ Supervisor	Up to 1	0	1	1	
Critical Time Intervention (CTI) Coaches	Up to 6	0	4	5	

Provider Type	IDN Workforce (FTEs)				
Care Transitions Administrative Support Worker	Up to 1	0	1	1	

C-4. IDN Community Project: Budget

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

The Care Transitions budget is presented below. Modifications have been made based on several factors:

Revenue- All project budgets have been adjusted to reflect the actual receipt or availability of future funding. Previously, our budgets were developed utilizing revenue projections based on the time period for which they could be earned. Revenue for 2018 is being reported in two new columns. The first identifies the actual incentive funding received in May, for the July to December 2017 reporting period. It represents a partial payment with the remainder expected soon. The second column for 2018, projects the receipt of the remaining prior period incentive funding, as well as incentive funding anticipated for November. N4H has also added a column for the period of January to June 2021 as we have been informed that our final potential incentive payment would be expected in May or June of 2021.

Expenses- Actual expenses (paid and invoices received) for the period of January to June of 2018 are presented. Anticipated expenses (including those for January to June not yet invoiced) are presented in the column reflecting July to December 2018. Given that final incentive funding is not expected to be received until May or June of 2021, we have projected expenses in that period as we conclude the waiver projects.

Reported actual expenses continue to be significantly below budget due in part to expense reporting limited to invoiced and paid. Another significant factor has been related to workforce challenges and our ability to achieve full staffing. During the reporting period, one coach left employment and a second was on an extended, partially unpaid leave. Two new coaches were recruited and both began employment full time at the beginning of June. Technology costs are expected to increase with the additional staff. Barrier Reduction funds have not been utilized at rates originally projected. Some of this is due to the ramping up of the coach caseloads. In addition, coaches have worked diligently to utilize other funding resources existing within the community for this purpose.

TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual	CY 2018 (Yr3) January to June Actual	CY 2018 (Yr3) July to December Projected	CY 2019 (Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) Projected
C1: Care Transitions Revenue (New)	$ 230,012	$ 128,807	$ 331,217	$ 460,024	$ 468,542	$ 238,530
C1: Care Transitions Revenue (Rollover)		$ 218,891	$ 264,562	$ 282,184	$ 149,169	$ 34,464
Total Revenue	$ 230,012	$ 347,698	$ 595,779	$ 742,208	$ 617,711	$ 272,994
Salary and benefits- Transitions Coaches (6.0 fte) and Administrative Assistant (1.0 fte)		$ 70,066	$ 262,097	$ 509,089	$ 498,598	$ 235,000
Technology (Laptops, phones, software)	$ 8,955	$ 7,374	$ 25,000	$ 28,515	$ 28,515	$ 10,000
Barrier Reduction Funds (Client Emergency funds and Interpretation Services)		$ 281	$ 20,000	$ 40,000	$ 40,000	$ 20,000
Occupancy	$ 2,166	$ 5,415	$ 6,498	$ 15,435	$ 16,134	$ 8,067
Subtotal	$ 11,121	$ 83,136	$ 313,595	$ 593,039	$ 583,247	$ 273,067
Variation to Budget (Transfer Funds to Subsequent Year)	$ 218,891	$ 264,562	$ 282,184	$ 149,169	$ 34,464	$ (73)

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

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

Organization/Provider	Agreement Executed (Y/N)
The Mental Health Center of Greater Manchester	Y

C-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project. NOTE: Project C1: Care Transitions does not require the use of standardized assessment tools. If the IDN chooses to use any standardized assessment tools, please list them.

Network4Health worked with the other four regions implementing CTI to try to come to a consensus on the use of a recovery assessment and client satisfaction tool, however, this effort was not successful due to the unique timing of each region's implementation.

Standard Assessment Tool Name	Brief Description
Intake Assessment	The Self-Reporting Assessment will be facilitated by the Critical Time Intervention Coach or Director upon consent to participate in the CTI program and will assess, at a minimum, the number of hospitalizations, number of contacts with community organizations, number of emergency room visits, number of homeless days, number of incarcerations and interactions with law enforcement within the previous 12 months. The Intake Assessment will be completed once the program has been explained to the client and a signed consent has been obtained during the enrollment phase.
Recovery Assessment Tool	Network4Health has decided to utilize the "Illness Management and Recovery Scale". This instrument is in the public domain, and can be self-administered. It takes a consumer perspective to recovery, yields quantitative data from which we can monitor progress, and has sound psychometric properties including internal consistency, validity and reliability. The goal is to have clients complete the tool upon entrance to and at exit from the CTI program.
Client Satisfaction Tool	We will be utilizing a self-administered, participant satisfaction tool when the individual exits the CTI program. We will, at a minimum, include client's program experiences (communication with CTI Coach and other program staff, the responsiveness of staff, communication about the 3 stages of the program, discharge information), overall rating of program, and assessing if they would recommend the program to friends and/or family members.

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

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

Protocol Name	Brief Description	Use (Current/Under development)
Eligibility	Clients are referred to the program if experiencing one of three identified transitions including: discharge from inpatient settings or frequent emergency department visits, release from correctional settings, or transition from youth behavioral health care delivery system to adult behavioral health care system AND	Currently in use

	3 or more of the following challenges: lack of positive social and natural support networks, 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, employment challenges (e.g. unemployment, underemployed, or lack of employment skills) or suicide risk.	
Enrollment	The CTI Intervention is explained at an in-person meeting with the client and if the client agrees to enroll, a signed Consent to Participate will enroll them in the Program.	Currently in use
Patient Transition	The patient is assessed at baseline using the screening and assessment instruments, to assess patient's social and health needs, and to develop an Individualized Service Plan. The CTI Coach is very involved with the client during this period: accompanying him/her to most community appointments and helping them navigate community resources and relationships. CTI Coach focuses on patient's most urgent needs.	Currently in use
Patient Tryout	During months 4-6, the CTI protocol begins to transition the client to their developing support system. The CTI Coach has fewer meetings with client; however helps to trouble shoot any areas that still need resolution.	Currently in use
Patient Transfer of Care	During months 7-9, the CTI protocol requires the CTI Coach to remain involved with the client; however provides little direct service. The CTI Coach allows the client to solve problems independently, and together they develop and implement a plan for long-term goals.	Currently in use

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

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

Project Team Member	Roles and Responsibilities
[redacted]	Team Co-lead
[redacted]	Team Co-lead
[redacted]	Executive Director, Network4Health
[redacted]	Care Transitions Director
[redacted]	N4H Care Transitions Administrative Assistant
[redacted]	Project Manager
[redacted]	Team Member
[redacted]	Team Member

[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member
[redacted]	Team Member

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

Network4Health supported several trainings for C1 staff as noted above, and further described below. In addition, Network4Health is continuing to work with the other 4 Regions implementing CTI, and developing plans for ongoing consultation and training from Hunter College beyond the expiration of the multiregional contract, which is due to expire in December, 2018.

Phase 1 **CTI Kick-off Event (Completed - 6/1/2017)**

- CACTI staff member(s) attended this meeting and presented background, evidence and brief overview of the CTI model and addressed questions from attendees. Present were 10-15 participants from each of the 5 participating Regions. Invitations also extended to DHHS and MSLC. Attendees from Network4Health Included [redacted]: NAMI NH, [redacted]: Center for Life Management, [redacted]: Easterseals, [redacted]: Network4Health, [redacted]: Catholic Medical Center, [redacted]: Child and Family Services, [redacted]: Manchester Community Health Center, [redacted]: Hillsborough County Commissioner, [redacted]: Catholic Medical Center, and [redacted]: Moore Center.

Phase 2 ***1st*** **Staff Training (Completed - 11/15/17 & 11/16/17)**

CACTI delivered a 2 day in person training on the CTI model for CTI coaches. Network4Health had not hired any of the CTI Coaches at the time of this training; therefore, attendees from Network4Health included [redacted], [redacted], [redacted], and [redacted]. These four individuals are providing oversite and guidance to the CTI Coaches until they are able to attend the next Coach training provided by CACTI.

Supervisor Training (Completed - 12/18/17)

- CACTI delivered a one-day face-to-face training for master's level supervisors who will be providing clinical supervision to CTI teams. The four attendees from Network4Health had all previously attended the CTI Coach training in November. Training on the CTI

Implementation Self-Assessment measure was provided as part of this training. Network4Health's CTI Director participated in this this training.

***2nd* Staff Training (Completed 3/19/18 & 3/20/18)**

- CACTI delivered training on the CTI mode , which all current Network4Health's CTI coaches attended. This was delivered via traditional in-person two-day training. All CTI direct service staff and CTI supervisors participated in this training. Approximately 40 trainees from 5 Regions were expected. From IDN 4, the attendees were CTI Coaches [redacted], [redacted], [redacted], and [redacted], as well as the Care Transitions Administrative Assistant, [redacted].

Phase 3 **Coaching/Implementation Support to follow Program Launch**

- **Community of Practice Meetings (12/1/17 -6/30/19)** (Monthly beginning 12/20/17)
    - CoP meetings began in December 2017 and continue to occur monthly. Attendees include case managers and/or supervisors, and allow providers to receive technical support during the Implementation Phase. A locally-based CACTI consultant facilitates these meetings, with the goal of reducing their role, as they help local trainers assume primary leadership responsibilities. Meetings are held in-person or via web/phone depending on feasibility/cost issues.
- **Coaching Support for Individual Organizations (2/1/18 -12/31/20)** (Monthly beginning 1/31/18)
    - As individuals are enrolled in the CTI program, CACTI provides monthly telephone consultations to CTI Team (including Director and Coaches), at individual provider organizations. This ensures program staff have ample opportunity to receive and offer feedback, and provides assistance in identifying and overcoming challenges specific to their organization. Feedback may be provided on data collected via self-assessment tools that organizations can use to monitor fidelity to the CTI model.

Phase 4 **Train-the-Trainer (6/30/18-12/31/18)**

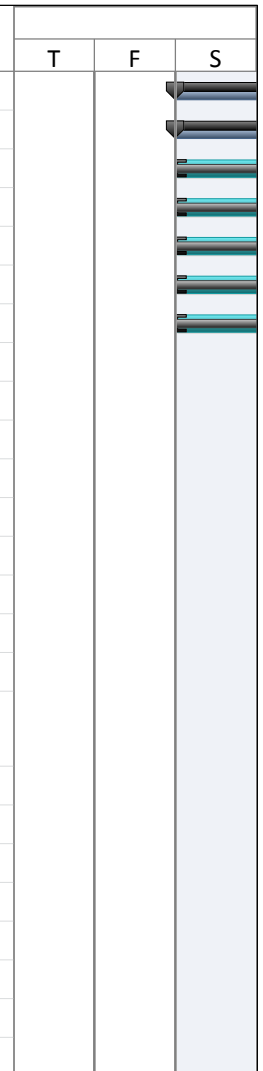
A combined CACTI/T3 team will provide a two-and-a-half-day in person Train-the-Trainer training to locally identified personnel who will assume responsibility for ongoing staff training and consultation after CACTI's role ends. Participants should have completed basic training in the CTI model and have prior training experience.

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				

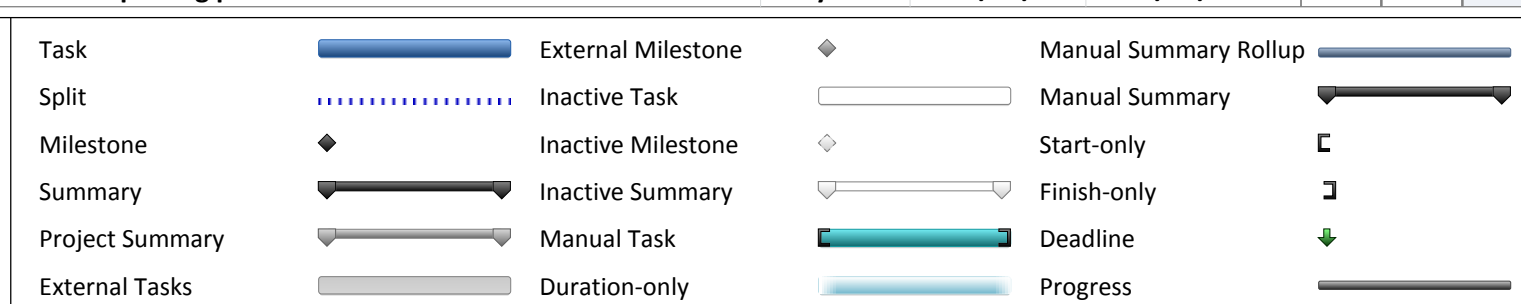
ID		Task Mode	Task Name	Duration	Start	Finish
1			**Care Transitions**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
2			**Recruitment**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
3	✓		Develop job descriptions for all Care Transitions positions	132 days	Sat 7/1/17	Sun 12/31/17
4	✓		Finalize job descriptions	132 days	Sat 7/1/17	Sun 12/31/17
5	✓		Recruit 1 Critical Time Intervention Director	132 days	Sat 7/1/17	Sun 12/31/17
6	✓		Recruit 1 Care Transitions Administrative Support Worker	132 days	Sat 7/1/17	Sun 12/31/17
7	✓		Recruit 6 Critical Time Intervention Coaches	132 days	Sat 7/1/17	Sun 12/31/17
8			**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
9	✓		Evaluate open positions if applicable	131 days	Mon 1/1/18	Sat 6/30/18
10	✓		Confirm need to recruit for open positions	131 days	Mon 1/1/18	Sat 6/30/18
11	✓		Recruit for open positions as needed	131 days	Mon 1/1/18	Sat 6/30/18
12			**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
13			Evaluate open positions if applicable	132 days	Sun 7/1/18	Mon 12/31/18
14			Confirm need to recruit for open positions	132 days	Sun 7/1/18	Mon 12/31/18
15			Recruit for open positions as needed	132 days	Sun 7/1/18	Mon 12/31/18
16			Identify criteria for potential Train-the-Trainer Candidates	132 days	Sun 7/1/18	Mon 12/31/18
17			Recruit up to 2-3 individuals to attend Train-the-Trainer training and provide ongoing CTI training to N4H	132 days	Sun 7/1/18	Mon 12/31/18
18			**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**
19			Evaluate open positions if applicable	130 days	Tue 1/1/19	Sun 6/30/19
20			Confirm need to recruit for open positions	130 days	Tue 1/1/19	Sun 6/30/19
21			Recruit for open positions as needed	130 days	Tue 1/1/19	Sun 6/30/19
22			**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**
23			Evaluate open positions if applicable	132 days	Mon 7/1/19	Tue 12/31/19
24			Confirm need to recruit for open positions	132 days	Mon 7/1/19	Tue 12/31/19
25			Recruit for open positions as needed	132 days	Mon 7/1/19	Tue 12/31/19



Project: Care TransitionsPP.mpp
Date: Thu 6/28/18

Task		External Milestone		Manual Summary Rollup	
Split		Inactive Task		Manual Summary	
Milestone		Inactive Milestone		Start-only	
Summary		Inactive Summary		Finish-only	
Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID		Task Mode	Task Name	Duration	Start	Finish
26			**Milestone reporting period**	**0 days**	**Tue 12/31/19**	**Tue 12/31/19**
27			Evaluate open positions if applicable	130 days	Wed 1/1/20	Tue 6/30/20
28			Confirm need to recruit for open positions	130 days	Wed 1/1/20	Tue 6/30/20
29			Recruit for open positions as needed	130 days	Wed 1/1/20	Tue 6/30/20
30			**Milestone reporting period**	**0 days**	**Tue 6/30/20**	**Tue 6/30/20**
31			Evaluate open positions if applicable	132 days	Wed 7/1/20	Thu 12/31/20
32			Confirm need to recruit for open positions	132 days	Wed 7/1/20	Thu 12/31/20
33			Recruit for open positions as needed	132 days	Wed 7/1/20	Thu 12/31/20
34			**Milestone reporting period**	**0 days**	**Thu 12/31/20**	**Thu 12/31/20**
35			**Training**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
36	✓		CTI training for Coaches	132 days	Sat 7/1/17	Sun 12/31/17
37	✓		CTI training for supervisor	132 days	Sat 7/1/17	Sun 12/31/17
38	✓		Multi regional Community of Practice meetings monthly	132 days	Sat 7/1/17	Sun 12/31/17
39			**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
40	✓		CTI training for Coaches	131 days	Mon 1/1/18	Sat 6/30/18
41			CTI training for supervisor	131 days	Mon 1/1/18	Sat 6/30/18
42	✓		Multi regional Community of Practice meetings monthly	131 days	Mon 1/1/18	Sat 6/30/18
43	✓		N4H Coaching from CACTI monthly via phone	131 days	Mon 1/1/18	Sat 6/30/18
44			**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
45			Train-the-Trainer training through CACTI	132 days	Sun 7/1/18	Mon 12/31/18
46			Multi regional Community of Practice meetings monthly	132 days	Sun 7/1/18	Mon 12/31/18
47			N4H Coaching from CACTI monthly via phone	132 days	Sun 7/1/18	Mon 12/31/18
48			**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**
49			Multi regional Community of Practice meetings monthly	130 days	Tue 1/1/19	Sun 6/30/19
50			N4H Coaching from CACTI monthly via phone	130 days	Tue 1/1/19	Sun 6/30/19
51			**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**



Project: Care TransitionsPP.mpp
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Task		External Milestone		Manual Summary Rollup	
Split		Inactive Task		Manual Summary	
Milestone		Inactive Milestone		Start-only	
Summary		Inactive Summary		Finish-only	
Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID		Task Mode	Task Name	Duration	Start	Finish
52			N4H Coaching from CACTI monthly via phone	132 days	Mon 7/1/19	Tue 12/31/19
53			**Milestone reporting period**	**0 days**	**Tue 12/31/19**	**Tue 12/31/19**
54			N4H Coaching from CACTI monthly via phone	130 days	Wed 1/1/20	Tue 6/30/20
55			**Milestone reporting period**	**0 days**	**Tue 6/30/20**	**Tue 6/30/20**
56			N4H Coaching from CACTI monthly via phone	132 days	Wed 7/1/20	Thu 12/31/20
57			**Milestone reporting period**	**0 days**	**Thu 12/31/20**	**Thu 12/31/20**
58			**Program Administration**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
59	✓		Develop assessment tools further	132 days	Sat 7/1/17	Sun 12/31/17
60	✓		Finalize protocols for patient assessment, treatment, management and referrals	132 days	Sat 7/1/17	Sun 12/31/17
61	✓		Develop additional performance measures focused on measures focused on continuity of care between treatment settings	132 days	Sat 7/1/17	Sun 12/31/17
62	✓		Begin accepting client referrals from N4H partners	132 days	Sat 7/1/17	Sun 12/31/17
63	✓		Perform data collection for reporting period	132 days	Sat 7/1/17	Sun 12/31/17
64			**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
65	✓		Finalize assessment tools	131 days	Mon 1/1/18	Sat 6/30/18
66	✓		Finalize multi regional contract with Hunter College for training	131 days	Mon 1/1/18	Sat 6/30/18
67	✓		Accept client referrals from N4H partners	131 days	Mon 1/1/18	Sat 6/30/18
68	✓		Perform data collection for reporting period	131 days	Mon 1/1/18	Sat 6/30/18
69			**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
70			Accept client referrals from N4H partners	132 days	Sun 7/1/18	Mon 12/31/18
71			Perform data collection for reporting period	132 days	Sun 7/1/18	Mon 12/31/18
72			**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**
73			Accept client referrals from N4H partners	130 days	Tue 1/1/19	Sun 6/30/19
74			Perform data collection for reporting period	130 days	Tue 1/1/19	Sun 6/30/19
75			**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**

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Task		External Milestone		Manual Summary Rollup	
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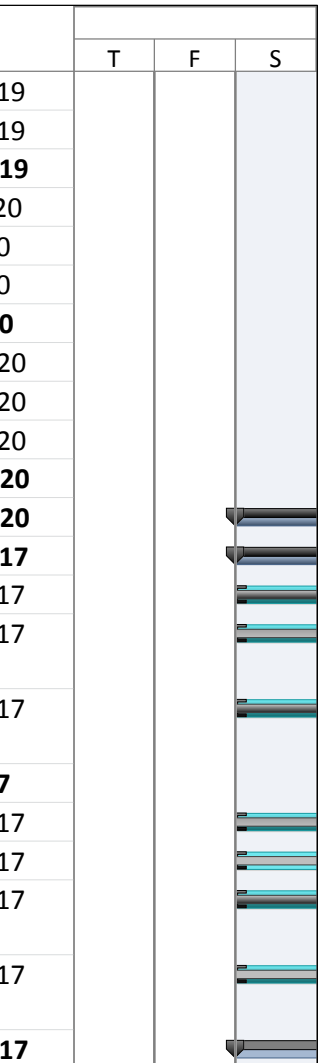
Milestone		Inactive Milestone		Start-only	
Summary		Inactive Summary		Finish-only	
Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID		Task Mode	Task Name	Duration	Start	Finish
76			Accept client referrals from N4H partners	132 days	Mon 7/1/19	Tue 12/31/19
77			Perform data collection for reporting period	132 days	Mon 7/1/19	Tue 12/31/19
78			**Milestone reporting period**	**0 days**	**Tue 12/31/19**	**Tue 12/31/19**
79			Accept client referrals from N4H partners until March	54 days	Wed 1/1/20	Mon 3/16/20
80			Discontinue accepting client referrals into CTI program	76 days	Tue 3/17/20	Tue 6/30/20
81			Perform data collection for reporting period	130 days	Wed 1/1/20	Tue 6/30/20
82			**Milestone reporting period**	**0 days**	**Tue 6/30/20**	**Tue 6/30/20**
83			Complete final phase for remaining clients	132 days	Wed 7/1/20	Thu 12/31/20
84			Educate community resources of CTI transition/closure	132 days	Wed 7/1/20	Thu 12/31/20
85			Perform data collection for reporting period	132 days	Wed 7/1/20	Thu 12/31/20
86			**Milestone reporting period**	**0 days**	**Thu 12/31/20**	**Thu 12/31/20**
87			**Monitoring**	**915 days**	**Sat 7/1/17**	**Thu 12/31/20**
88			**CTI team meetings**	**132 days**	**Sat 7/1/17**	**Sun 12/31/17**
89	✓		Evaluate need and set or adjust frequency of meetings	132 days	Sat 7/1/17	Sun 12/31/17
90	✓		Discuss caseload of CTI coaches and individual client cases as needed	132 days	Sat 7/1/17	Sun 12/31/17
91	✓		CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Sat 7/1/17	Sun 12/31/17
92			**Monthly CTI team meetings with CACTI**	**1 day**	**Mon 7/3/17**	**Mon 7/3/17**
93	✓		Report on progress, challenges and lessons learned	132 days	Sat 7/1/17	Sun 12/31/17
94	✓		Evaluate the fidelity of the CTI model	132 days	Sat 7/1/17	Sun 12/31/17
95	✓		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Sat 7/1/17	Sun 12/31/17
96	✓		Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Sat 7/1/17	Sun 12/31/17
97			**Monthly Care Transitions Team meetings**	**132 days**	**Sat 7/1/17**	**Sun 12/31/17**



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Task		External Milestone		Manual Summary Rollup	
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Milestone		Inactive Milestone		Start-only	
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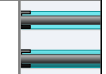
Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID		Task Mode	Task Name	Duration	Start	Finish
98	✓		CTI Director to report on progress	132 days	Sat 7/1/17	Sun 12/31/17
99	✓		Provide directional feedback for CTI team	132 days	Sat 7/1/17	Sun 12/31/17
100			**Milestone reporting period**	**0 days**	**Sun 12/31/17**	**Sun 12/31/17**
101			**CTI team meetings**	**131 days**	**Mon 1/1/18**	**Sat 6/30/18**
102	✓		Evaluate need and set or adjust frequency of meetings	131 days	Mon 1/1/18	Sat 6/30/18
103	✓		Discuss caseload of CTI coaches and individual client cases as needed	131 days	Mon 1/1/18	Sat 6/30/18
104	✓		CTI Director to evaluate caseload and provide support or adjustments as appropriate	131 days	Mon 1/1/18	Sat 6/30/18
105			**Monthly CTI team meetings with CACTI**	**131 days**	**Mon 1/1/18**	**Sat 6/30/18**
106	✓		Report on progress, challenges and lessons learned	131 days	Mon 1/1/18	Sat 6/30/18
107	✓		Evaluate the fidelity of the CTI model	131 days	Mon 1/1/18	Sat 6/30/18
108	✓		Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	131 days	Mon 1/1/18	Sat 6/30/18
109	✓		Provide coaching support to CTI coaches based on feedback as appropriate	131 days	Mon 1/1/18	Sat 6/30/18
110			**Care Transitions Team meetings**	**131 days**	**Mon 1/1/18**	**Sat 6/30/18**
111	✓		Evaluate need and set or adjust frequency of meetings	131 days	Mon 1/1/18	Sat 6/30/18
112	✓		CTI Director to report on progress	131 days	Mon 1/1/18	Sat 6/30/18
113	✓		Provide directional feedback for CTI team	131 days	Mon 1/1/18	Sat 6/30/18
114			**Milestone reporting period**	**0 days**	**Sat 6/30/18**	**Sat 6/30/18**
115			**CTI team meetings**	**132 days**	**Sun 7/1/18**	**Mon 12/31/18**
116			Evaluate need and set or adjust frequency of meetings	132 days	Sun 7/1/18	Mon 12/31/18
117			Discuss caseload of CTI coaches and individual client cases as needed	132 days	Sun 7/1/18	Mon 12/31/18



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Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID		Task Mode	Task Name	Duration	Start	Finish	T	F	S
118			CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Sun 7/1/18	Mon 12/31/18			
119			**Monthly CTI team meetings with CACTI**	**132 days**	**Sun 7/1/18**	**Mon 12/31/18**			
120			Report on progress, challenges and lessons learned	132 days	Sun 7/1/18	Mon 12/31/18			
121			Evaluate the fidelity of the CTI model	132 days	Sun 7/1/18	Mon 12/31/18			
122			Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Sun 7/1/18	Mon 12/31/18			
123			Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Sun 7/1/18	Mon 12/31/18			
124			**Care Transitions Team meetings**	**132 days**	**Sun 7/1/18**	**Mon 12/31/18**			
125			Evaluate need and set or adjust frequency of meetings	132 days	Sun 7/1/18	Mon 12/31/18			
126			CTI Director to report on progress	132 days	Sun 7/1/18	Mon 12/31/18			
127			Provide directional feedback for CTI team	132 days	Sun 7/1/18	Mon 12/31/18			
128			**Milestone reporting period**	**0 days**	**Mon 12/31/18**	**Mon 12/31/18**			
129			**CTI team meetings**	**130 days**	**Tue 1/1/19**	**Sun 6/30/19**			
130			Evaluate need and set or adjust frequency of meetings	130 days	Tue 1/1/19	Sun 6/30/19			
131			Discuss caseload of CTI coaches and individual client cases as needed	130 days	Tue 1/1/19	Sun 6/30/19			
132			CTI Director to evaluate caseload and provide support or adjustments as appropriate	130 days	Tue 1/1/19	Sun 6/30/19			
133			**Monthly CTI team meetings with CACTI**	**130 days**	**Tue 1/1/19**	**Sun 6/30/19**			
134			Report on progress, challenges and lessons learned	130 days	Tue 1/1/19	Sun 6/30/19			
135			Evaluate the fidelity of the CTI model	130 days	Tue 1/1/19	Sun 6/30/19			
136			Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	130 days	Tue 1/1/19	Sun 6/30/19			

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Task		External Milestone		Manual Summary Rollup	
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Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID		Task Mode	Task Name	Duration	Start	Finish	T	F	S
137			Provide coaching support to CTI coaches based on feedback as appropriate	130 days	Tue 1/1/19	Sun 6/30/19			
138			**Care Transitions Team meetings**	**130 days**	**Tue 1/1/19**	**Sun 6/30/19**			
139			Evaluate need and set or adjust frequency of meetings	130 days	Tue 1/1/19	Sun 6/30/19			
140			CTI Director to report on progress	130 days	Tue 1/1/19	Sun 6/30/19			
141			Provide directional feedback for CTI team	130 days	Tue 1/1/19	Sun 6/30/19			
142			**Milestone reporting period**	**0 days**	**Sun 6/30/19**	**Sun 6/30/19**			
143			**CTI team meetings**	**132 days**	**Mon 7/1/19**	**Tue 12/31/19**			
144			Evaluate need and set or adjust frequency of meetings	132 days	Mon 7/1/19	Tue 12/31/19			
145			Discuss caseload of CTI coaches and individual client cases as needed	132 days	Mon 7/1/19	Tue 12/31/19			
146			CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Mon 7/1/19	Tue 12/31/19			
147			**Monthly CTI team meetings with CACTI**	**132 days**	**Mon 7/1/19**	**Tue 12/31/19**			
148			Report on progress, challenges and lessons learned	132 days	Mon 7/1/19	Tue 12/31/19			
149			Evaluate the fidelity of the CTI model	132 days	Mon 7/1/19	Tue 12/31/19			
150			Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Mon 7/1/19	Tue 12/31/19			
151			Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Mon 7/1/19	Tue 12/31/19			
152			**Care Transitions Team meetings**	**132 days**	**Mon 7/1/19**	**Tue 12/31/19**			
153			Evaluate need and set or adjust frequency of meetings	132 days	Mon 7/1/19	Tue 12/31/19			
154			CTI Director to report on progress	132 days	Mon 7/1/19	Tue 12/31/19			
155			Provide directional feedback for CTI team	132 days	Mon 7/1/19	Tue 12/31/19			
156			**Milestone reporting period**	**1 day**	**Tue 12/31/19**	**Tue 12/31/19**			
157			**CTI team meetings**	**130 days**	**Wed 1/1/20**	**Tue 6/30/20**			

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Task	External Milestone	Manual Summary Rollup	
Split	Inactive Task	Manual Summary	
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Summary	Inactive Summary	Finish-only	
Project Summary	Manual Task	Deadline	
External Tasks	Duration-only	Progress	

ID		Task Mode	Task Name	Duration	Start	Finish	T	F	S
158			Evaluate need and set or adjust frequency of meetings	130 days	Wed 1/1/20	Tue 6/30/20			
159			Discuss caseload of CTI coaches and individual client cases as needed	130 days	Wed 1/1/20	Tue 6/30/20			
160			CTI Director to evaluate caseload and provide support or adjustments as appropriate	130 days	Wed 1/1/20	Tue 6/30/20			
161			**Monthly CTI team meetings with CACTI**	**130 days**	**Wed 1/1/20**	**Tue 6/30/20**			
162			Report on progress, challenges and lessons learned	130 days	Wed 1/1/20	Tue 6/30/20			
163			Evaluate the fidelity of the CTI model	130 days	Wed 1/1/20	Tue 6/30/20			
164			Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	130 days	Wed 1/1/20	Tue 6/30/20			
165			Provide coaching support to CTI coaches based on feedback as appropriate	130 days	Wed 1/1/20	Tue 6/30/20			
166			**Care Transitions Team meetings**	**130 days**	**Wed 1/1/20**	**Tue 6/30/20**			
167			Evaluate need and set or adjust frequency of meetings	130 days	Wed 1/1/20	Tue 6/30/20			
168			CTI Director to report on progress	130 days	Wed 1/1/20	Tue 6/30/20			
169			Provide directional feedback for CTI team	130 days	Wed 1/1/20	Tue 6/30/20			
170			**Milestone reporting period**	1 day	**Tue 6/30/20**	**Tue 6/30/20**			
171			**CTI team meetings**	**132 days**	**Wed 7/1/20**	**Thu 12/31/20**			
172			Evaluate need and set or adjust frequency of meetings	132 days	Wed 7/1/20	Thu 12/31/20			
173			Discuss caseload of CTI coaches and individual client cases as needed	132 days	Wed 7/1/20	Thu 12/31/20			
174			CTI Director to evaluate caseload and provide support or adjustments as appropriate	132 days	Wed 7/1/20	Thu 12/31/20			
175			**Monthly CTI team meetings with CACTI**	**132 days**	**Wed 7/1/20**	**Thu 12/31/20**			
176			Report on progress, challenges and lessons learned	132 days	Wed 7/1/20	Thu 12/31/20			
177			Evaluate the fidelity of the CTI model	132 days	Wed 7/1/20	Thu 12/31/20			

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Task		External Milestone		Manual Summary Rollup	
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Project Summary		Manual Task		Deadline	
External Tasks		Duration-only		Progress	

ID		Task Mode	Task Name	Duration	Start	Finish	T	F	S
178			Receive and apply feedback from CACTI on maintaining the fidelity of the CTI model as appropriate	132 days	Wed 7/1/20	Thu 12/31/20			
179			Provide coaching support to CTI coaches based on feedback as appropriate	132 days	Wed 7/1/20	Thu 12/31/20			
180			**Care Transitions Team meetings**	**132 days**	**Wed 7/1/20**	**Thu 12/31/20**			
181			Evaluate need and set or adjust frequency of meetings	132 days	Wed 7/1/20	Thu 12/31/20			
182			CTI Director to report on progress	132 days	Wed 7/1/20	Thu 12/31/20			
183			Provide directional feedback for CTI team	132 days	Wed 7/1/20	Thu 12/31/20			
184			**Milestone reporting period**	**1 day**	**Thu 12/31/20**	**Thu 12/31/20**			

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Projects D: Capacity Building Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

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

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

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

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

During this reporting period, the Elliot Health System and Network4Health made significant progress in developing the Partial Hospitalization Program (PHP) and other programs designed to better care for individuals in our community with substance use disorders. A large portion of the work has been focused on the four technical challenges outlined in the Revised Project Plan submitted on March 30th, 2018. An updated project plan is included as Attachment_D1.1.

1. **EHR Scope & Timeline:** The most significant risk to implementing the PHP was securing IT resources to scope the project and perform the build. Given an enterprise-wide EHR refuel project currently in process with a go-live within 3 weeks of our PHP, securing this resource within the Elliot Health System was a considerable undertaking. Nonetheless, the scope was completed during the second quarter with the assistance of our Chief Nursing Informatics Officer. In order to meet our commitment of an October 1 go-live for the PHP, the Elliot Health System hired three outside Epic consultants to perform the build and meet our deadline. They will begin their work on July 9th, 2018 with a completion date set for September 28th, 2018.
2. **Space:** Together, with Elliot senior leadership, the PHP team has made a final decision to locate the PHP on the EHS campus at 445 Cypress St. Suite #7. A walk-through of the space with IT, Purchasing and Facilities departments has been completed and all appropriate hardware, cabling, furniture, and facility improvements have been noted and are on order.
3. **Human Resources:** Despite the lack of psychiatric/SUD providers in the area, we have made significant progress in our recruitment efforts. Of the 6 positions posted, 4 have accepted positions within the Partial Hospitalization Program. As shown in the chart below, the remaining positions are for a LICSW and a RN. We have plans to post for the administrative positions, PSR and Billing Coordinator, towards the beginning of August.

Position	FTE's	Comments/notes
Director	0.5	Filled – started 02/18
PSR	*1.0*	Will post in Aug.
Billing Coordinator	*1.0*	Will post in Aug.
LICSW	*1.0*	Open
MLADC	*1.0*	Filled – start mid-Sept.
1 Clinical case manager, BSW- Intake	*1.0*	Filled – start Aug. 6th
1 CRSW	*1.0*	Filled – start Aug. 6th
1 RN	*1.0*	Open
1 Nurse Practitioner or Psychiatrist	*0.6*	Filled – start July 30th
1 Outreach worker - year 2	*1.0*	Not posted yet

4. **Billing and Contracting:** All payers have been notified of our intent to provide PHP services as an outpatient hospital department service as of October 1. A Medicaid application was submitted to DHHS in March to enroll Elliot Hospital as an "Outpatient SUD Program". The application is still pending. Billing codes, referral and prior authorization requirements and medical necessity policies for each payer have been identified.

In addition to our four focus areas, Network4Health has made progress in other areas such as marketing, urine drug testing panels and programming. A detailed project plan is available in Attachment D3.1. During this quarter the team met with Elliot's Marketing Department to discuss the best way to market the PHP and to develop a marketing/communication plan. The first strategy is to spotlight the PHP in Elliot's "Your Wellness Matters" newsletter, which will reach over 200,000 homes in New Hampshire in the Fall/Winter of 2018. Internal efforts will consist of formal and informal information sessions on PHP and the other SUD initiatives through Senior Leadership meetings, Manager's & Director's meetings, Elliot Physician Operating Board, and Office Manager's meeting, some of which have already occurred. We also plan to develop a brochure, FAQ's, and website (both Elliot's and N4H's) with some possible print advertising and social media. As we approach go-live, the PHP Director will be presenting the program to our N4H partners. As a team, we decided to hold off before developing our outreach program. While we continue to raise awareness around our SUD programs, a formal outreach program will be developed later in the project timeline as we focus on other priorities.

Discussions with the Elliot lab have taken place to determine the type of urine drug testing that will be done within the PHP. Refinements to current panels are being done to better meet the needs of the program.

Lastly, a considerable amount of work has been done from a programming perspective. All policies and procedures that were previously developed under Serenity Place have been vetted and revamped to better compliment the design of the program within the Elliot Health System. All new policies and procedures are outlined in more detail in D-7 below. A high-level workflow has been developed and will continuously be updated as we work closely with IT. The PHP team has also been working with the Clinical Director of Co-Occurring Disorders, the E4 project, to understand the Dual Diagnosis Capability in Addiction Treatment (DDCAT) framework. This has been helpful in aligning our PHP with evidence-based treatment models during the development of our program.

Although the technical challenges outlined above are critical to any program, through our work with other SUD initiatives at the Elliot, another critical component to implementing a SUD program was

identified: Culture/Stigma. Throughout that last several months it has become increasingly clear that the adaptive challenges of implementing substance use disorder programs within a health system could be just as crippling to a project as a lack of resources or space. To illustrate this, through a grant from Foundation for Healthy Communities, the Elliot was tasked to provide greater access to timely and coordinated care for those in the emergency department with substance use disorders.

Beginning in March, a SUD ED Steering Committee was created with individuals representing a wide range of departments within the Elliot Health System; ED Medical Director, ED Director, Case Management, Inpatient Behavioral Health Nurse Manager, Hospitalist Director, ED Nursing, Behavioral Health Medical Director, Behavioral Health Educator, Director of Substance Use Disorders, Clinical Informatics, Compliance, Chief Nursing Information Officer, Director of Behavioral Health and Director for the Center for Clinical Excellence. The Steering Committee met weekly through the end of May and we accomplished the following:

1. Developed current state process map for patients with SUD's
2. Solicited feedback via survey or face-to-face interviews from front-line staff across all shifts; nursing, physicians, Inpatient behavioral health providers, Elliot's Behavioral Health Emergency Response Team (BERT), case management, Behavioral Health Patient and Family Advisory Counsel and The Mental Health Center of Greater Manchester. Some of the topics addressed:
    a. Experience
    b. System of Care
    c. Opportunities for improvement
    d. Adequacy of resources available (internal and external)
3. Conducted direct observation sessions with SUD patients that arrive in the ED
4. Conducted literature review of evidence-based practices in the ED for the SUD population
5. With the data collected, the Steering Committee narrowed all barriers identified into 5 main groups:
    a. Education and Training
    b. Culture
    c. Process
    d. Caregiver Burnout
    e. Resources
6. Countermeasures were then identified to address the 5 main barriers:
    a. Education and Training: to address education and training, culture
    b. Resources/Process
    c. Caregiver burnout
7. With the approval from Senior Leadership, key members of the Steering Committee have committed to a 1 ½ day Rapid Performance Improvement Workshop (RPIW) scheduled for July 23rd and July 26th. During the RPIW, the Steering Committee will breakout into smaller groups to accomplish developing and testing solid processes and well-defined plans for each of the three countermeasures listed above. This will allow for a more expedited and organized execution in the ED.

Going through this process has been invaluable to the system. In the beginning it seemed obvious that we needed education and more resources in the ED to effectively and efficiently care for those with

SUD's. However, it was bringing this team together, with many different perspectives and motivations that will bring about real change in our ED. The meetings were very "safe" in that over time, members of the Steering Committee felt comfortable to express their real feelings about caring for this population. Over the last several weeks we could feel the change happening. It was a feeling of coming together to help solve the issues we were having and that each member of the ED staff had a role in caring for those with SUD's, not just adding another staff member to take care of it all. This was an exercise to begin a real cultural change, which takes time. We anticipate that the education developed to address stigma, SUD as a chronic disease, and "what help really looks like" will be implemented across the health system, including the PHP.

Another program that the Elliot Health System is fully engaged in is expanding access to Medication Assisted Treatment through Elliot Primary Care, with the assistance of another grant through The Foundation for Healthy Communities. With MAT being the "gold standard" in treatment for opioid addiction, Elliot has hired a MAT Nurse Care Coordinator and MLADC to complete a team for the implementation of a comprehensive best practice model within two primary care offices. In the coming weeks we will be working on technical aspects of this model, such as role delineation, workflows, point of care urine drug testing and documentation. Taking our lessons learned from the ED project, we are also concentrating on some adaptive challenges such as stigma identification and training within the primary care practice setting. Once a well-developed model is in place and education and training have been rolled out, our goal is to replicate this model in more primary care practices, which will expand access considerably and help to supplement the treatment being provided in the ED, Drug Court IOP and our PHP. The Director of Substance Use Services has already begun engaging the Elliot primary care network through Academic Detailing, brief one-on-one information sessions about MAT and to solicit feedback (fears, barriers, perceptions).

Lastly, we would like to mention the success of the Drug Court IOP that was taken over from Serenity Place on March 1, 2018. In June, the Hillsborough County North Drug Court celebrated five graduates in a heartfelt ceremony at the Hillsborough Superior Court in Manchester, NH. The ceremony highlighted to the team the importance of putting a larger focus on positive outcomes. This small act will play a significant role when we talk about ending stigma, minimizing caregiver burnout and boosting morale.

Each of these programs, ED, IOP, PHP and MAT will expand access to best practices and more coordinated care for individuals in our community. Each program will feed into each other as well as other programs in the community and we recognize that we cannot develop them in a vacuum. As we continue to define and develop each program, lessons learned and efficiencies gained from each project will be used to complement the whole Substance Use Disorder continuum within the Elliot Health System and across Network4Health.

D-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list of all of the progress toward targets or goals, that the program has achieved. Targets required by the STCs include, but should not be limited to:

- *Number of individuals served (during reporting period and cumulative)*
- *All performance measures identified in the evaluation project plan.*

The Partial Hospitalization Program is on track to open on October 1, 2018 and therefore, the chart below indicates that there have been no admissions to date.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
# of admissions	Up to 19 by 12/31/18	0	0	
# of program completions	Up to 80% by 12/31/18	0	0	
# of chart reviews per quarter	Up to 50% by 12/31/18	0	0	
# of patients successfully referred to aftercare programs in the community	Up to 80% by 12/31/18	0	0	

D-3. IDN Community Project: Workforce Staffing

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

The chart below shows our progress in staffing as of 06/30/18. As indicated in the narrative above, we have hired 4 out of 6 positions posted, however, given our go-live date of October 1, they will be on-boarded during the next quarter.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Program Director	Up to 1 FTE	0	0.5	0.5	
Patient Service Representative	Up to 1 FTE	0	0	0	
Billing Coordinator	Up to 1 FTE	0	0	0	
BH (MH & SUD) Clinicians – LMHC Counselor and/or LADC/MLADC Counselor	Up to 2 FTE	0	0	0	
Care Coordinator (i.e., Case Manager) – BSW, LMA or RN	Up to 1 FTE	0	0	0	
Care Enhancer (i.e., Peer Support Specialist)- Patient Advocate; CRSW or other national certification	Up to 1 FTE	0	0	0	
Care Coordinator – RN for medication management	Up to 1 FTE	0	0	0	
Psychiatric Clinician – Psychiatrist or Psychiatric Advanced Practice Nurse	Up to 0.6 FTE	0	0	0	
Care Enhancer (i.e., Outreach worker) – Community Health Worker	Up to 1 FTE	0	0	0	

D-4. IDN Community Project: Budget

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

The Expansion of Substance Use Disorder Treatment Options budget is presented below. Modifications have been made based on several factors:

Revenue- All project budgets have been adjusted to reflect the actual receipt or availability of future funding. Previously, our budgets were developed utilizing revenue projections based on the time period for which they could be earned. Revenue for 2018 is being reported in two new columns. The first identifies the actual incentive funding received in May for the July to December 2017 reporting period. It represents a partial payment with the remainder expected soon. The second column, for 2018, projects the receipt of the remaining prior period incentive funding as well as incentive funding anticipated for November. N4H has also added a column for the period of January to June 2021 as we have been informed that our final potential incentive payment would be expected in May or June of 2021.

Expenses- Actual expenses (paid and invoices received) for the period of January to June of 2018 are presented. Anticipated expenses (including those for January to June not yet invoiced) are presented in the column reflecting July to December 2018. Given that final incentive funding is not expected to be received until May or June of 2021, we have projected expenses in that period as we conclude the waiver projects.

Due to delay in implementation of the planned partial hospitalization program that resulted from the closing of Serenity Place, there continues to be no expenses paid for this project. The Program Director and Project Management expenses are paid from the Project Design and Capacity Building funding. New staff have been hired and will begin employment in July and August with admissions to the new program being accepted by October 1, 2018.

TRANSFORMATON FUNDS	ACTUAL CY 2017 (Yr2)	ACTUAL CY 2018 Jan-Jun	PROJECTED CY 2018 Jul-Dec	PROJECTED CY 2019 (Yr4)	PROJECTED CY 2020 (Yr5)	PROJECTED CY 2021 (Yr6)
Expected Patient Volume with Ramp Up			19	137	137	69
D3 Revenue (New)	$ 230,012	$ 128,807	$ 331,217	$ 460,024	$ 468,542	$ 238,530
D3 Revenue (Rollover)		$ 230,012	$ 358,819	$ (94,408)	$ (76,750)	$ 8,924
Generated Revenue from Billing			$ 113,891	$ 820,013	$ 820,013	$ 413,603
Total Revenue	**$ 230,012**	**$ 358,819**	**$ 803,927**	**$ 1,185,630**	**$ 1,211,805**	**$ 661,057**
Salaries and Benefits	$ -		$ 258,353	$ 775,060	$ 790,561	$ 395,281
Rent, Utilities & Housekeeping	$ -		$ 10,000	$ 30,000	$ 30,000	$ 15,000
Cell Phones			$ 360	$ 1,080	$ 1,080	$ 540
Lab	$ -		$ 2,850	$ 20,520	$ 20,520	$ 10,260
Food/Snacks	$ -		$ 2,850	$ 20,520	$ 20,520	$ 10,260
Travel/Training	$ -		$ 8,600	$ 8,600	$ 8,600	$ 4,300
Marketing	$ -		$ 3,000	$ 3,000	$ 3,000	$ 1,500
Miscellaneous Supplies	$ -		$ 1,200	$ 3,600	$ 3,600	$ 1,800
Start Up Costs						
EMR build and implementation	$ -		$ 475,000	$ 400,000	$ 325,000	$ 200,000
FF&E	$ -		$ 27,811			
Security	$ -		$ 6,000			
IT Hardware/Infrastructure	$ -		$ 40,000			
Facility/Construction	$ -		$ 50,000			
Signage (internal and external)	$ -		$ 1,000			
Miscellaneous/Contingency	$ -		$ 4,000			
On-boarding	$ -		$ 7,310			
Total Expenses	**$ -**	**$ -**	**$ 898,334**	**$ 1,262,380**	**$ 1,202,881**	**$ 638,941**
Variation to Budget (Transfer Funds to Proceeding Year)	$ 230,012	$ 358,819	$ (94,408)	$ (76,750)	$ 8,924	$ 22,117

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

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

Organization/Provider	Agreement Executed (Y/N)
Elliot Health System	Y

D-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project.

Standard Assessment Tool Name	Brief Description
Modified Mini Screen (MMS)	The MMS is designed to identify people in need of an assessment in the domains of mood disorders, anxiety disorders, and psychotic disorders. It is not diagnostic per se, but is intended as an indicator of when a more thorough mental health assessment is required.
Mental Health Screening Form	The Mental Health Screening Form is a 17-item screen that examines lifetime history of mental health. Questions 1-4 are about the client's history of psychiatric treatment. Questions 5-17 are each associated with a particular mental health diagnosis. Positive responses to these items suggest the need for more intensive assessment.
AUDIT	The AUDIT screens for alcohol use disorders (past-year time frame). This instrument is a "Gold standard" for providing an indication of both hazardous/harmful alcohol use as well as alcohol dependence.
DAST	The DAST 20: 1) provides a brief, simple, practical, but valid method of identifying individuals who are using psychoactive drugs; and 2) yields a quantitative index score regarding the degree of problems related to the drug use. DAST 20 scores are highly diagnostic with respect to a DSM diagnosis of psychoactive drug dependence.
Addiction Severity Index	This is one of the most widely used substance use instruments for screening, assessment, and treatment planning. The instrument was designed as a structured interview to examine alcohol and drug dependence, the frequency of use, and other psychosocial areas that have been affected by using substances.

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

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

The protocols included below will be utilized once the partial hospitalization program go live. Policies are specific to the PHP, unless they say Elliot Hospital. In that case, they are hospital-wide protocols that will be applied to the PHP.

Protocol Name	Brief Description	Use (Current/Under Development)
Admissions	To establish criteria for appropriate admission to the Partial Hospitalization Program.	Current
Appointments and Rescheduling	This policy is designed to set reasonable and appropriate expectations for setting appointments by clients and staff.	Current
Assessment	Assessment and service planning is an ongoing, collaborative, continuous and person-centered process at the Elliot Hospital Substance Use Disorder Services programs. This process is a mutual exploration of the client's issues and strengths, complemented by the staff's professional perspective and recommendations resulting in a jointly created plan with mutually agreed upon goals.	Current
Behavioral Health Emergencies	To identify the necessary processes that need to occur in the event of a behavioral health emergency **.**	Current
Case Management	This policy is designed to identify the activities, roles and responsibilities of a case manager in a substance use disorder program.	Current
Clients Rights	This policy is designed to outline the rights of clients within the Department of Substance Use Services.	Current
Clinical Documentation	This policy is designed to ensure that client information is maintained in an organized and secure manner.	Current
Clinical Supervision	This policy is designed to ensure that the highest possible professional standards are adhered to in the provision of behavioural health services	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Complaints (Elliot Hospital)	To provide a guideline for appropriate and timely management pf client complaints and grievances while complying with state and federal laws, regulations and guidance.	Current
Compliance (Elliot Hospital)	To describe the policy and procedure related to the federal and state False Claims Act, whistleblower protections and the Elliot Health System ("EHS") compliance program in accordance with federal and state regulations.	Current
Confidentiality (Elliot Hospital)	The purpose of this policy is to clearly identify uses and disclosures of PHI that require a valid patient authorization.	Current
Critical Incidents (Elliot Hospital)	To provide a support mechanism for staff who have been involved in a work-related traumatic event or critical incident.	Current
Cultural Competency	To foster greater understanding and compatibility of staff for the diversity of cultural, racial, ethnic, and socioeconomic backgrounds of our clients.	Current
Dangerous Items on Premises	To ensure the safety of all clients, their family members and staff.	Current
Discharges	This policy is designed to affirm a client's right to refuse treatment. The policy also affirms the program's right to end treatment when the client is not deemed to be maintaining minimal standards of commitment to treatment, and this has been communicated to the client.	Current
Discharge Documentation	This policy is designed to ensure that the treatment record will adequately communicate the nature and course of treatment provided, as well as the reasons for the termination of treatment.	Current
Ethical Conduct	To ensure that all actions by staff are performed in an ethical manner.	Current
Medical Clearance	Participants in the Partial Hospitalization Program need to be medically cleared to participate in the group therapy program. The program is not clinically appropriate for participants with compromised medical conditions.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Progress Notes	This policy is designed to ensure that all contact with clients, their families, and other outside agencies is appropriately documented, to ensure the maintenance of a consistent record of treatment, and a means for the provision of continuity of care and the verification of professional conduct.	Current
Psychiatric Prescribing and Documentation	This policy is designed to ensure the following: that all contact of staff prescribers with clients is performed in a professional manner, that the most appropriate treatment is provided to clients, that a consistent and complete medical record of treatment is maintained, and that a means for the provision of continuity of care and the verification of professional conduct is maintained.	Current
Record Maintenance (Elliot Hospital)	This policy is designed to accomplish the goals of maintaining accurate, relevant and useful records for Elliot Health System ("EHS"), and to maintain these records for reasonable, proper retention periods.	Current
Referrals	The Substance Use Disorder Services (SUDS) Department creates and maintains linkages and relationships with other service providers, organizations and professionals in the community in order to ensure clients have the opportunity to access the most effective, coordinated and comprehensive services available. The SUDS Department, with the informed consent and participation of the client, may make referrals to another service within Elliot Hospital or to external resources, at any time in service delivery (i.e., prior to offering service, while service is ongoing or when service is being terminated).	Current
Social Media (Elliot Hospital)	The purpose of this policy is to enable the EHS workforce to embrace social networking and to provide parameters to work within. This policy establishes a set of rules for any activity and participation in "social media".	Current
Subpoenas	This policy is designed to clarify how and when staff should release information of any sort to courts and government investigators.	Current
Suicide Assessment	This policy is designed to ensure the safety of all clients by effectively assessing suicidal and homicidal ideation and intent.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Tobacco (Elliot Hospital)	Elliot's primary mission is to protect the health of those in our community while promoting and supporting a community culture of healthier living. Elliot Health System has, therefore, set this policy regarding tobacco use on campus.	Current
Witnessing Documents	To clarify the legal limits of staff as signatory witnesses for their clients.	Current

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

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

Project Team Member	Roles and Responsibilities
[redacted] Elliot Health System	Executive Sponsor • Champion the project and the team. • Responsible for the overall success of the project. • Provide high-level oversight, direction, and support. • Empower the project owner/business sponsor and project manager. • Ensure project meets goals. • Address any significant budget issues. • Approve any major scope changes. • Ensure resources are available to deliver within the scope and schedule, as needed. • Approve project initiation and conclusion. • Meet regularly throughout effort and review project progress. • Approve the project charter(s).
[redacted] Elliot Health System [redacted] Elliot Health System [redacted] Makin' It Happen	Project Co-leads • Ensure project objectives are being met. • Responsible for the overall success of the project. • Partner to oversee project deliverables, schedule, budget, and human resources. • Champion the project and the team. • Provide high-level updates to Steering Committee as needed. • Approve or recommend scope changes. • Review and provide approval at key junctures of the project. • Approve needed changes to policies and procedures as identified by the project team. • Meet regularly with project manager and the project team as needed.

[redacted] Elliot Health System	Project Manager
	• Responsible for the overall success of the project.
	• Manage and lead the project team.
	• Recruit project staff and consultants, where necessary.
	• Manage coordination of the partners and working groups engaged in project work.
	• Facilitate scope definition as part of the project charter.
	• Facilitate project plan development to set expectations for deliverables and schedule.
	  ○ Develop and maintain a detailed project schedule.
	  ○ Manage project deliverables in line with the project plan.
	  ○ Record and manage project issues and escalate where necessary.
	  ○ Resolve cross-functional issues at project level.
	  ○ Manage project scope and change control and escalate issues where necessary.
	  ○ Monitor project progress and performance.
	  ○ Provide status reports to the project sponsor and EPMO.
	• Coordinate with, and update progress to project executive sponsor, co-leads, and project team.
	• Coordinate phase sign-offs.
	• Work closely with stakeholders to ensure the project meets business needs.
	• Manage project close out and evaluation and ensure appropriate transition to operations.

[redacted] Chairman of the Board, Derry Friendship Center [redacted] Derry Friendship Center [redacted] MHCGM [redacted] Director, Office of Catholic Identity, CMC [redacted] Clinical and Supportive Services Manager, Families in Transition [redacted] Farnum Center at Easter Seals	Team Members • Actively support and endorse project. • Ensure quality outcomes. • Participate in project team meetings as needed. • Actively participate in project activities as needed to support the successful delivery of project outcomes. • Ensure cross-team communication and collaboration. • Identify cross-team issues and coordinate issue resolution. • Document operations process flows, gaps and recommended changes. • Work with the co-leads to ensure the needs of the Network can be supported. • Ensure that all team members have the information they need to complete their work successfully.

	• Provide recommended changes for policies and procedures based on the project outcomes. • Review project deliverables for completeness, quality, and compliance with established project standards. • Problem solve and embrace change. • Step in and help whenever needed.

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

The training plan below outlines the training topics to be addressed within the first four months of hire. Since our new staff is being on-boarded at different times, the expectation is that they will have completed the training schedule below no later than the "Date of Completion" indicated on the plan.

Training	Type of Provider	Date of Completion
Orientation	All providers and support staff	21-Sep-18
Effective Documentation	ARNP, RN, LCMHC, Case Manager	21-Sep-18
Policies and Procedures for PHP	All providers and support staff	21-Sep-18
Confidentiality	ARNP, RN, LCMHC, Case Manager	28-Sep-18
Ethics and Clinical Boundaries	ARNP, RN, LCMHC, Case Manager	5-Oct-18
Assessment Tools	ARNP, RN, LCMHC, Case Manager	12-Oct-18
Safety in the Workplace	All providers and support staff	19-Oct-18
Counseling Skills (EBP's)	ARNP, RN, LCMHC, Case Manager	26-Oct-18
Developing Outcomes	ARNP, RN, LCMHC, Case Manager	2-Nov-18
Differential Diagnosis	ARNP, RN, LCMHC, Case Manager	9-Nov-18
Co-occurring Disorder Treatment	ARNP, RN, LCMHC, Case Manager	16-Nov-18
Suicidality and Crises Interventions	ARNP, RN, LCMHC, Case Manager	23-Nov-18
Family Training	ARNP, RN, LCMHC, Case Manager	30-Nov-18
Motivation Interviewing	ARNP, RN, LCMHC, Case Manager	7-Dec-18
Mental Health First Aid	All providers and support staff	14-Dec-18

Project Scoring: IDN Community Project Process Milestones

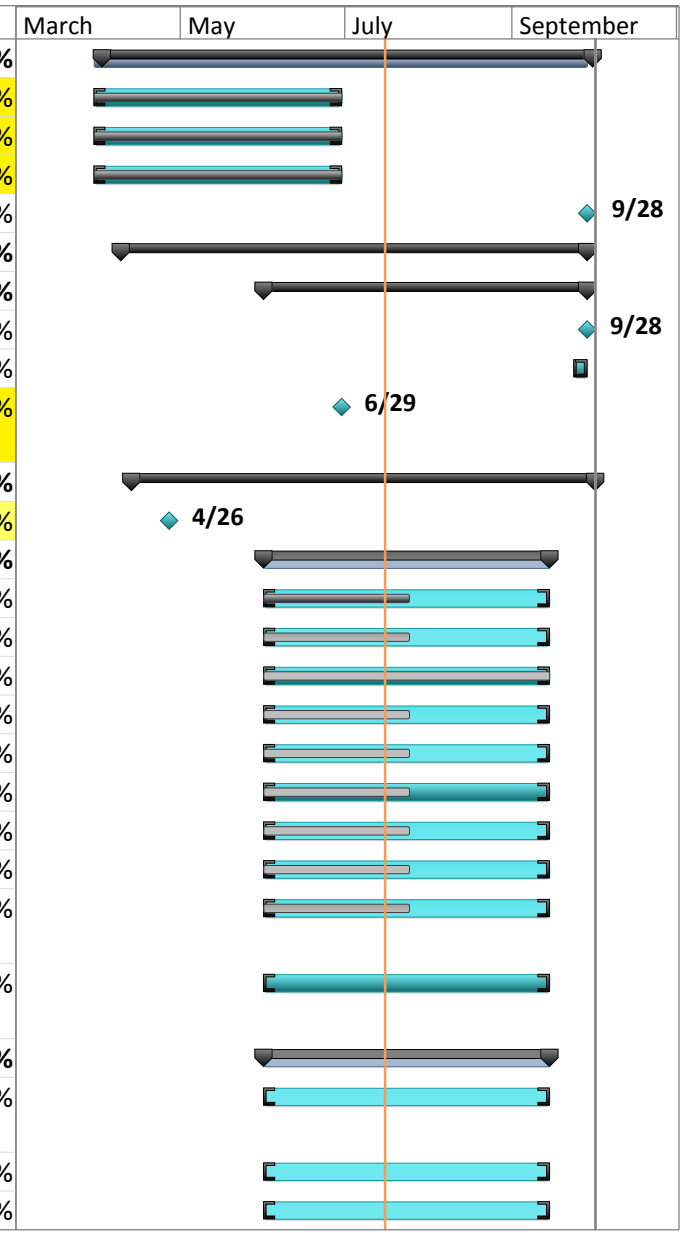
DHHS will use the tool below to assess each IDN's Community Projects activities. Grayed areas indicate that no submission is expected for the time frame. A score of "Met" will be scored for a timely and complete submission. A score of "Not Met" will be scored for late and/or incomplete information.

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	Training schedule and table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	Driven Project as required in A-1.3					

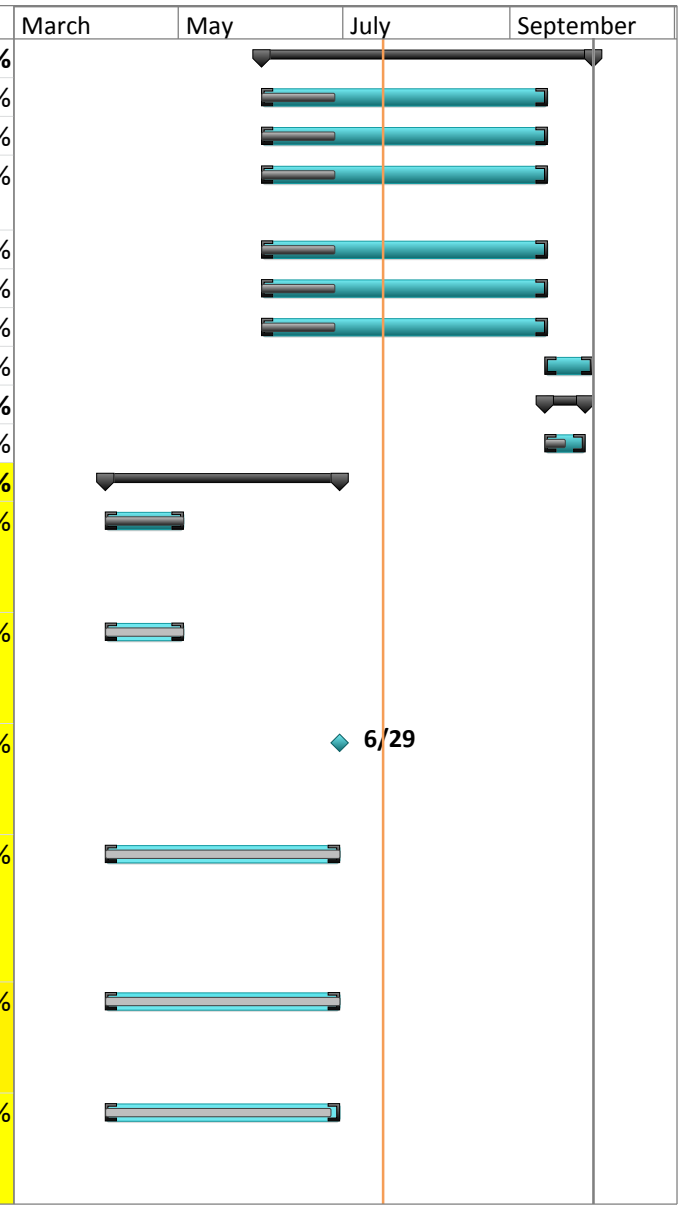
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Mon 7/16/18

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
1	**IT Epic Build**	**131 days**	**Mon 4/2/18**	**Sun 9/30/18**	**No**	**77%**
2	Scope Project	66 days	Fri 3/30/18	Fri 6/29/18	No	100%
3	Develop Timeline	66 days	Fri 3/30/18	Fri 6/29/18	No	100%
4	Develop Cost	66 days	Fri 3/30/18	Fri 6/29/18	No	100%
5	Epic Build	60 days	Mon 7/9/18	Fri 9/28/18	Yes	0%
6	**Workflows**	**125 days**	**Mon 4/9/18**	**Fri 9/28/18**	**No**	**40%**
7	**Epic Workflows**	**86 days**	**Fri 6/1/18**	**Fri 9/28/18**	**No**	**0%**
8	Design Workflows	86 days	Fri 6/1/18	Fri 9/28/18	Yes	0%
9	Epic Training	5 days	Mon 9/24/18	Fri 9/28/18	No	0%
10	Operational Workflows	60 days	Mon 4/9/18	Fri 6/29/18	Yes	100%
11	**Space & Equipment**	**122 days**	**Fri 4/13/18**	**Mon 10/1/18**	**No**	**34%**
12	Determine where	10 days	Fri 4/13/18	Thu 4/26/18	Yes	100%
13	**FF&E**	**76 days**	**Fri 6/1/18**	**Fri 9/14/18**	**No**	**50%**
14	Desks	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
15	Desk chairs	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
16	Group room chairs	76 days	Fri 6/1/18	Fri 9/14/18	No	100%
17	Lobby furniture	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
18	Shredder bins	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
19	Kitchen equipment	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
20	Artwork	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
21	Water cooler	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
22	Medical Equipment and supplies	76 days	Fri 6/1/18	Fri 9/14/18	No	50%
23	Internal/External Signage	76 days	Fri 6/1/18	Fri 9/14/18	No	0%
24	**Security**	**76 days**	**Fri 6/1/18**	**Fri 9/14/18**	**No**	**0%**
25	Hospital key system locks	76 days	Fri 6/1/18	Fri 9/14/18	No	0%
26	Panic Buttons	76 days	Fri 6/1/18	Fri 9/14/18	No	0%
27	Cameras	76 days	Fri 6/1/18	Fri 9/14/18	No	0%



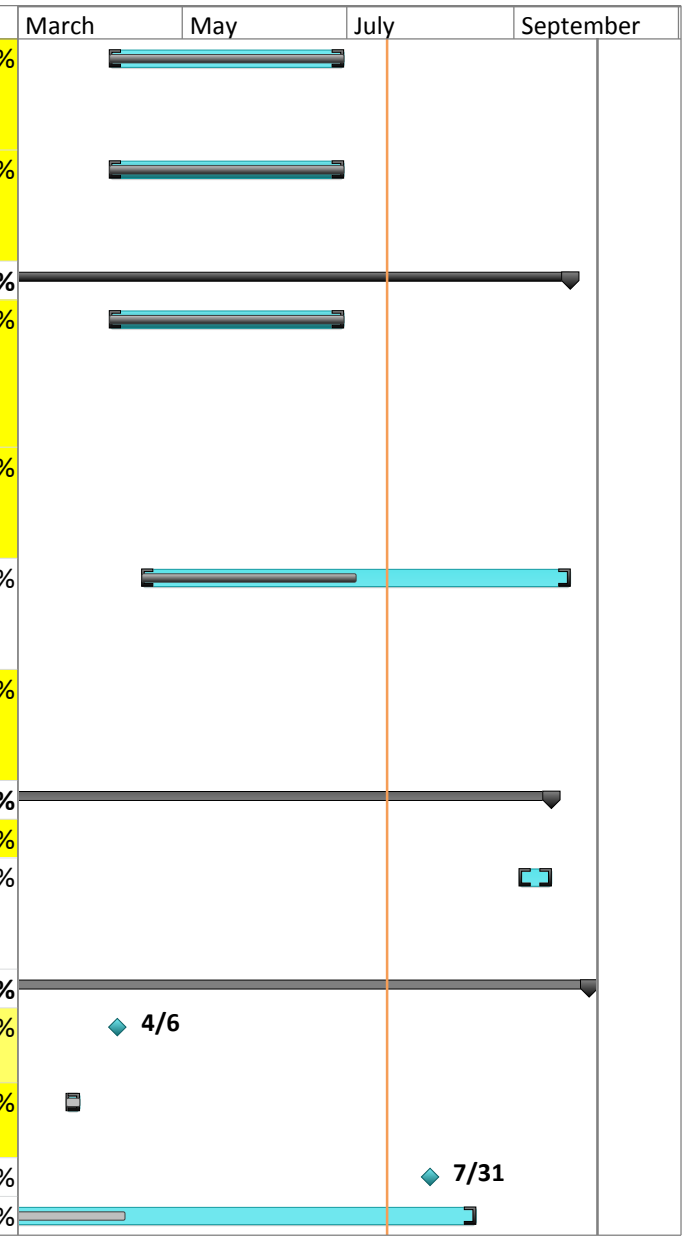
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Mon 7/16/18

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
28	**IT Equipment**	**87 days**	**Fri 6/1/18**	**Mon 10/1/18**	**No**	**24%**
29	Computers/Laptops	76 days	Fri 6/1/18	Fri 9/14/18	No	25%
30	Monitors	76 days	Fri 6/1/18	Fri 9/14/18	No	25%
31	Printers - type and location	76 days	Fri 6/1/18	Fri 9/14/18	No	25%
32	Fax	76 days	Fri 6/1/18	Fri 9/14/18	No	25%
33	Phones	76 days	Fri 6/1/18	Fri 9/14/18	No	25%
34	Data Drops	76 days	Fri 6/1/18	Fri 9/14/18	No	25%
35	Cell Phones?	12 days	Fri 9/14/18	Mon 10/1/18	No	0%
36	**Office Supplies**	**11 days**	**Fri 9/14/18**	**Fri 9/28/18**	**No**	**50%**
37	Business Cards	11 days	Fri 9/14/18	Fri 9/28/18	No	50%
38	**Billing**	**63 days**	**Wed 4/4/18**	**Fri 6/29/18**	**No**	**99%**
39	Determine if it will be hospital based billing or professional only	21 days	Wed 4/4/18	Wed 5/2/18	No	100%
40	Determine which billing form is required; 1500 or UB	21 days	Wed 4/4/18	Wed 5/2/18	No	100%
41	Determine enrollment requirements for each insurance	63 days	Wed 4/4/18	Fri 6/29/18	Yes	100%
42	Notify insurances of new program; Determine if contracts need to be modified	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
43	Determine if site visit is required and by whom	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
44	Determine the staffing requirements for each insurance	63 days	Wed 4/4/18	Fri 6/29/18	No	95%



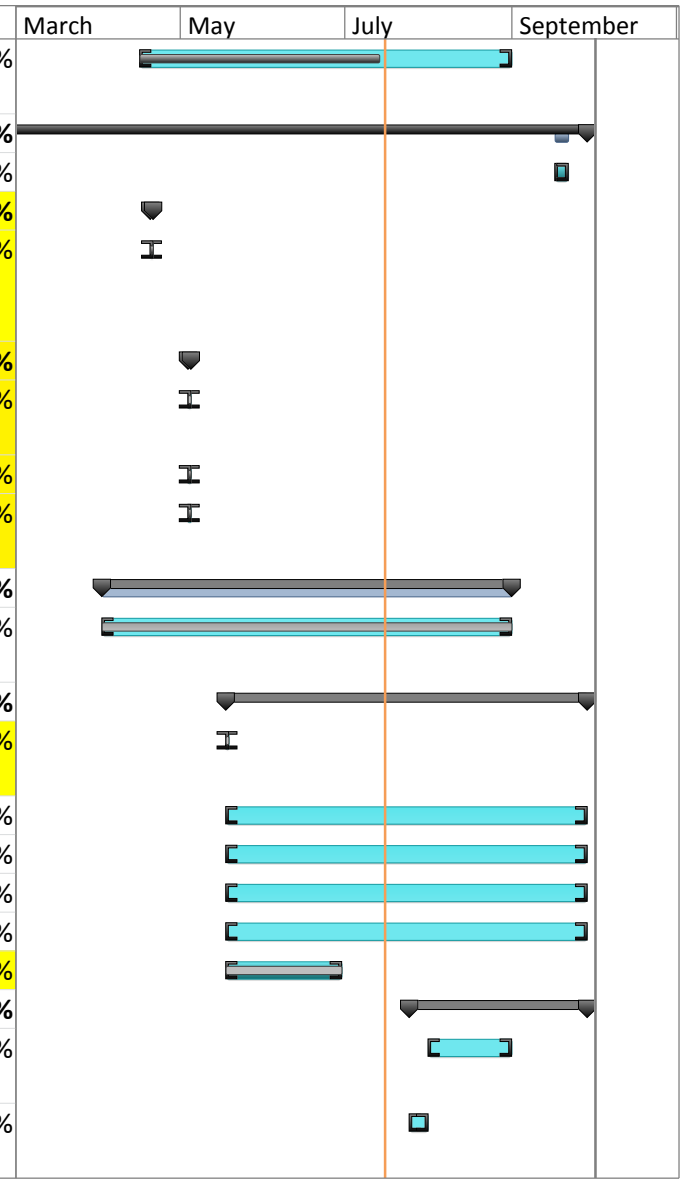
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Mon 7/16/18

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
45	Determine the CPT and Dx codes required for each insurance	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
46	Create encounter form (if not being entered directly into Epic)	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
47	**Regulatory/Compliance**	**167 days**	**Thu 2/1/18**	**Fri 9/21/18**	**No**	**73%**
48	Determine if certification/licensing is required and by whom	63 days	Wed 4/4/18	Fri 6/29/18	No	100%
49	Creation of appropriate 42 CFR Part 2 consents	18 days	Thu 2/1/18	Mon 2/26/18	No	100%
50	Work with IT to incorporate 42 CFR Part 2 into the Epic system	115 days	Mon 4/16/18	Fri 9/21/18	No	50%
51	Create fax cover letter with 42 CFR Part 2 language	18 days	Thu 2/1/18	Mon 2/26/18	No	100%
52	**Finance**	**177 days**	**Thu 1/11/18**	**Fri 9/14/18**	**No**	**52%**
53	Create PHP Dept	11 days	Thu 1/11/18	Thu 1/25/18	No	100%
54	Complete General Ledger Maintenance Form	10 days	Mon 9/3/18	Fri 9/14/18	No	0%
55	**Human Resources**	**325 days**	**Mon 7/3/17**	**Fri 9/28/18**	**No**	**76%**
56	Create Job Descriptions	200 days	Mon 7/3/17	Fri 4/6/18	Yes	100%
57	Send to Position Control	5 days	Mon 3/19/18	Fri 3/23/18	No	100%
58	Post Positions	77 days	Mon 4/16/18	Tue 7/31/18	Yes	67%
59	Conduct Interviews	285 days	Mon 7/17/17	Fri 8/17/18	No	67%



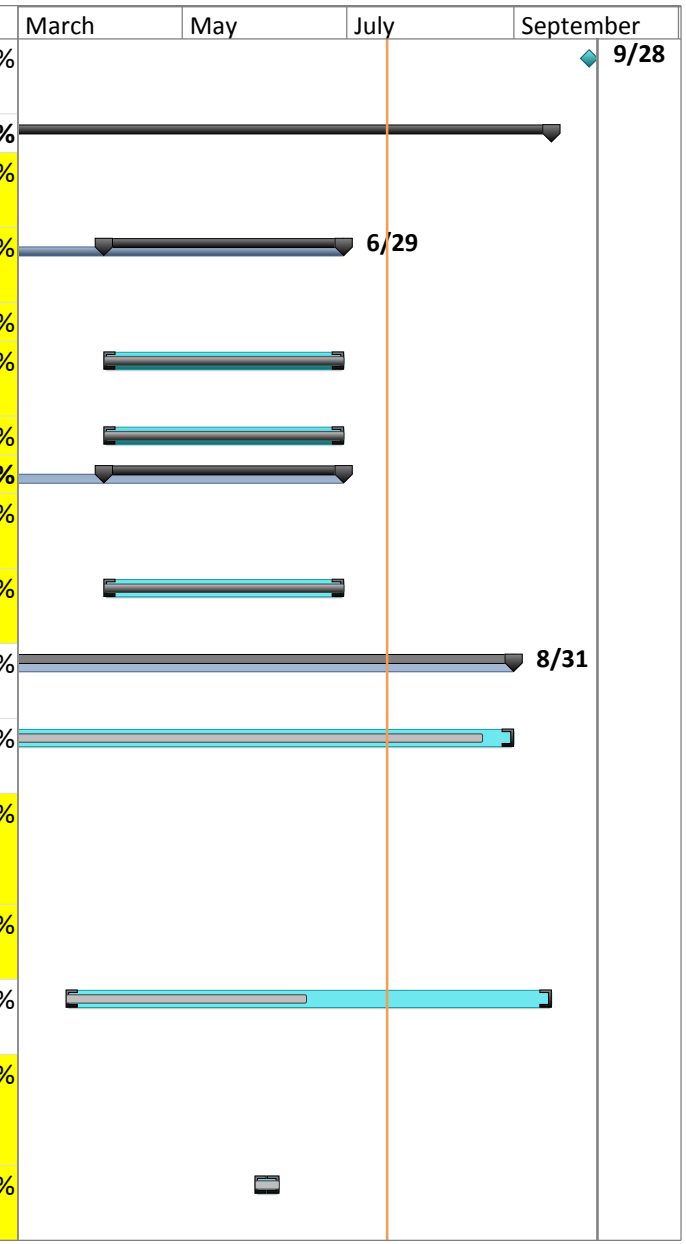
Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Mon 7/16/18

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
60	Medical Staff - Priviledges	100 days	Mon 4/16/18	Fri 8/31/18	No	65%
61	**On board**	**225 days**	**Mon 11/20/17**	**Fri 9/28/18**	**No**	**0%**
62	Submit SARFs	5 days	Mon 9/17/18	Fri 9/21/18	No	0%
63	**HIM**	**1 day**	**Fri 4/20/18**	**Fri 4/20/18**	**No**	**100%**
64	Schedule meeting to discuss new department	1 day	Fri 4/20/18	Fri 4/20/18	No	100%
65	**Lab**	**1 day**	**Fri 5/4/18**	**Fri 5/4/18**	**No**	**100%**
66	Schedule meeting with Lab	1 day	Fri 5/4/18	Fri 5/4/18	No	100%
67	In house or outsource?	1 day	Fri 5/4/18	Fri 5/4/18	No	100%
68	Determine panels needed	1 day	Fri 5/4/18	Fri 5/4/18	No	100%
69	**Legal**	**110 days**	**Mon 4/2/18**	**Fri 8/31/18**	**No**	**100%**
70	Determine if any contracts need review	110 days	Mon 4/2/18	Fri 8/31/18	No	100%
71	**Marketing**	**96 days**	**Fri 5/18/18**	**Fri 9/28/18**	**No**	**7%**
72	Schedule meeting with marketing	1 day	Fri 5/18/18	Fri 5/18/18	No	100%
73	Internal	96 days	Fri 5/18/18	Fri 9/28/18	No	0%
74	External	96 days	Fri 5/18/18	Fri 9/28/18	No	0%
75	Website	96 days	Fri 5/18/18	Fri 9/28/18	No	0%
76	Pamphlets	96 days	Fri 5/18/18	Fri 9/28/18	No	0%
77	Timeline & Plan	31 days	Fri 5/18/18	Fri 6/29/18	No	100%
78	**Outreach**	**48 days**	**Wed 7/25/18**	**Fri 9/28/18**	**No**	**0%**
79	Develop Road Show Presentation	23 days	Wed 8/1/18	Fri 8/31/18	No	0%
80	Determine who to present to	5 days	Wed 7/25/18	Tue 7/31/18	No	0%



Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Mon 7/16/18

ID	Task Name	Duration	Start	Finish	Milestone	% Complete
81	Schedule presentations	43 days	Wed 8/1/18	Fri 9/28/18	Yes	0%
82	**Programming**	**206 days**	**Fri 12/1/17**	**Fri 9/14/18**	**No**	**88%**
83	General program description	3 days	Wed 2/21/18	Fri 2/23/18	No	100%
84	Detailed program description	65 days	Mon 4/2/18	Fri 6/29/18	Yes	100%
85	Hours	1 day	Tue 2/27/18	Tue 2/27/18	No	100%
86	Interdisciplinary Team Roles	65 days	Mon 4/2/18	Fri 6/29/18	No	100%
87	Persons served	65 days	Mon 4/2/18	Fri 6/29/18	No	100%
88	**Services Offered**	**65 days**	**Mon 4/2/18**	**Fri 6/29/18**	**No**	**100%**
89	Group Names and Topics	21 days	Fri 12/1/17	Fri 12/29/17	No	100%
90	Other services-descriptions	65 days	Mon 4/2/18	Fri 6/29/18	No	100%
91	Policy & Procedure Manual	195 days	Mon 12/4/17	Fri 8/31/18	Yes	96%
92	Develop policies and procedures	196 days	Fri 12/1/17	Fri 8/31/18	No	95%
93	Identify and adapt screening and assessment tools	20 days	Mon 12/4/17	Fri 12/29/17	No	100%
94	Develop Patient Handbook	21 days	Fri 12/1/17	Fri 12/29/17	No	100%
95	Program Evaluation Metrics	130 days	Mon 3/19/18	Fri 9/14/18	No	50%
96	Develop Program Training Plan and Schedule	21 days	Fri 12/1/17	Fri 12/29/17	No	100%
97	Notify Safety Department of PHP	7 days	Mon 5/28/18	Tue 6/5/18	No	100%



Attachment D3.1
D3 Partial Hospitalization Program Project Plan
Mon 7/16/18

ID	Task Name	Duration	Start	Finish	Milestone	% Complete	March	May	July	September
98	Appoint Safety Trainer	21 days	Mon 9/3/18	Mon 10/1/18	No	0%				

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

IDNs were required to complete an IDN Community Project Implementation and Infrastructure Plan for each selected community project. Provide a detailed narrative which describes the progress made on required activities, timelines, key milestones, progress assessment check points and evaluation metrics.

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

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

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

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

Include a narrative which provides detail of Key Organizations and Providers that have been off-boarded as well as new partners. The narrative should relate to tables E-2 through E-7 and identify progress, barriers and plans to address those barriers within your IDN and reflected within your project plan and timeline.

Progress Update

Through our integration focused project (E4) Network4Health aims to support the increase of dual diagnosis identification and evidence-based integrated treatment competencies for patients with both a severe mental illness and substance use disorder at participating Network4Health organizations. The Integrated Treatment of Co-occurring Disorders (ITCOD) project team continues its implementation plan to use two parallel approaches to enhance the identification and treatment of patients with co-occurring disorders.

As previously reported, the ITCOD Project created and trained a team of New Hampshire-based subject matter experts in dual diagnosis capability assessments and integrated treatment of co-occurring disorders program structure through formal training and practical assessment shadowing with trainers from the Center for Evidence Based Practice at Case Western Reserve University (CEBP). The team is led by the Network4Health's Director of Co-occurring Disorders (COD), Katie Sawyer LICSW, MLADC. Katie continues monthly consultation sessions with CEBP to discuss the Dual Diagnosis Capability (DDC) assessment and quality improvement process.

A DDC assessment report includes scores on 35 benchmarks across 7 domains within the Dual Diagnosis Capability Index. A rational narrative and recommendations are provided to organizations for each of the 7 domains.

During the January 2018 – June 2018 project period, the ITCOD DDC Assessment team completed the following project milestones and activities.

New Dual Diagnosis Capability Assessments

- One new Dual Diagnosis Capability in Mental Health Treatment assessment was completed in March 2018 for Network4Health partner organization Pastoral Counseling Services at their Manchester location. The assessment focused on their Outpatient Therapy Services. Pastoral Counseling Services mission is "to be a Center of Excellence and diversity which integrates psychological theory and spiritual sensitivity through psychotherapy, consultation, and education. We partner with social service, educational, faith, and business communities to further this mission".
- The Pastoral Counseling Services assessment was the first experience for the Network4Health DDC Assessment team to complete a DDC assessment without the CEBP consultants on-site. The team felt positive about the experience and the training they had received. They also were able to contact the CEBP team for phone consultation as needed.

DDC Assessment Report Delivery

- DDC assessment reports were delivered to the Center for Life Management and Families in Transition-New Horizons in January 2018 based on their October 2017 DDC program assessments.
- A DDC Assessment report was delivered in April 2018 to Pastoral Counseling Services based on their March 2018 DDC program assessment.

DDC Assessment Report Presentations

- A meeting was held with each of the DDC assessment programs (Center for Life Management, Families in Transition-New Horizons, The Mental Health Center of Greater Manchester and Pastoral Counseling Services), with their Network4Health DDC Assessors, the Network4Health ITCOD Clinical Director and for the initial 3 organizations, a consultant from CEBP. Report meetings reviewed scores and findings of the DDC assessment as documented in the DDC assessment report and began conversations around recommended areas for quality improvement to be further refined in the quality improvement plan (QIP) development process.

DDC Quality Improvement Plans (QIP)

- 4 Dual Diagnosis Capability Quality Improvement Plans (DDC QIPs) were completed with the following organizations during the reporting period:
    - **Center for Life Management (CLM)**
        - <u>QIP Timeline:</u> June 2018 to May 2019
        - <u>Anticipated Program Re-assessment:</u> Q2 2019
        - <u>QIP Goals:</u>

          CLM has a number of goals for their staff, and their Adult Services Program to increase the treatment capabilities for serving individuals with co-occurring disorders. CLM intends on training up to 75% of their clinical staff in Motivational Interviewing (from basic to intermediate/advanced skills), with an additional training for Clinical Supervisors, to increase Supervisor's skills in evaluating the application of these skills, and support clinician's use of motivational interview (MI) skills in their day to day work. Through their QIP, CLM will have access to up to 9 hours of Consultation from an MI Trainer, to reinforce their efforts and address supervisory challenges.

          In addition, CLM will provide basic Stage of Change (SOC) training, and Core Competencies of Substance Use Disorder (SUD) Treatment for up to 75% of their clinical staff. To help support learning and application, CLM will develop a

standardized format and log for Supervisors to use during clinical supervisions that includes the review of Mental Illness (MI), Stages Of Change (SOC) and Core Competency skills and application of skills in their daily work. Changes within the EMR will be amended to include Stage of Change Assessments in treatment notes, and will also include the ability to collect data from client charts that monitors patient's responses to the DAST and AUDIT screening tools to help assure that patients are receiving stage appropriate treatments and interventions.

CLM's goal of increasing staff's attendance (up to 35% of staff) at SUD/COD group supervision will be enhanced in part by also developing a clinician-based sharing forum. To support staff and encourage sharing and application of knowledge and skills, two staff from CLM will attend the New England Institute of Addiction Studies (NEIAS): Best Practices or School of Addiction Studies and share their experiences with other clinical staff.

CLM aims to increase the resources that are available for patients and their families, as well as clinicians, by developing a list of local resources and making them available both in waiting areas, and clinical spaces.

Completed QIP Activities:
To date, CLM has developed an internal ITCOD workgroup/development committee which began in February 2018 and continues to meet weekly. The goal of this workgroup is to assure implementation and problem-solving strategies are being applied to the overall goals of the ITCOD QIP activities, as well as on an agency wide basis to increase services for the COD population. Focus areas have included group development, training/supervision needs, and use of peer supports/CRSWs. In addition, a MLADC on staff in the CSP Program has developed and continues to lead a SUD/co-occurring disorders "group supervision", which started in March and continues to meet on a weekly basis.

A CSP Program Case Manager attended NEIAS School of Addiction Studies during the first week of June 2018; this foundation acquired will help launch CLM efforts toward improved collaborative care for those with co-occurring diagnoses. Initial progress has been made on EMR enhancements related to stages of change and outcome measures (DAST/AUDIT), and two new CLM groups for Substance Use Recovery are scheduled to begin in late July 2018.

CLM has begun to schedule Motivational Interviewing & Stages of Change Trainings for Community Support Program (CSP) staff for September. These include three explicit trainings aimed at staff within CSP, including: clinical staff, supervisors/CSP team leads, case managers and community support workers. In addition, Core Competency Training will be scheduled for October 2018.

On a community level, CLM has partnered with Continuum of Care Facilitator/South Central Public Health Network to produce and distribute a Substance Use Treatment/Recovery "Resource Guide" for this region.

- **Families in Transition- New Horizons (FIT-NH)**
  - QIP Timeline: June 2018 to May 2019
  - Anticipated Program Re-assessment: Q2 2019

- QIP Goals:
  FIT-NH has a number of goals for their staff, and their Family Willows Program to increase their capabilities for serving individuals with co-occurring disorders. Goals include increasing staff's knowledge, skills and application of Motivational Interviewing and Stage of Change (including Stage Wise Treatment). FIT-NH intends on training clinical staff in MI (basic and intermediate), with an additional training for Clinical Supervisors, to increase Supervisor's skills in evaluating the application of these skills, and support clinician's use of MI/SOC skills in their day to day work. A Staging Tool will be explored and reviewed with staff, to use both in initial assessment and ongoing through clinical work. Up to 10 employees will attend a "Stigma Reduction" (or related) training as well.

  FIT-NH will be reviewing and adjusting job descriptions and expectations to include Core Competencies and skill sets for both existing and future employees within the Willows Program. To support staff, FIT-NH intends on supporting licensure activities for both Supervisors and staff in regards to both MH and SUD licensing/certification within the State of NH.

  To help assure comprehensive treatment services and referrals as needed, FIT-NH will be implementing routine Screening and Assessment for COD, for both new and existing patients. They will review and explore the use of a standardized tool to screen for mental health related symptoms (i.e. CAAPE-5, GAIN-SS, PHQ, BDI-II, etc.); and amend the Electronic Health Record (EHR) to reflect the completion and results of the screening tool(s).

  FIT-NH aims to increase the resources that are available for patients and their families, as well as clinicians, by developing and displaying a list of local resources serving the COD population (including but not limited to peer support agencies and meetings, IOP and inpatient options, Medication Assisted Treatment (MAT) programs, etc.), as well as general education on COD and/or Mental Health conditions. In addition, they aim to collect clinician resources being shared with patients (both paper and electronic copies) and review; leading to a centralized location that contains resources, and is accessible to all staff.

  Completed Activities:
  To date, FIT-NH has secured dates in September 2018 for Stages of Change and Motivational Interviewing training from the Change Company, with a follow up Supervisory Training scheduled for Q4 2018. FIT-NH also completed a Stigma Reduction training for 23 staff members with trainers from the Mental Health Center of Greater Manchester in June 2018.

  Staff is engaging in bi-weekly individual supervision and weekly peer collaboration, in an effort to move toward increased licensure among staff. In addition to staff working towards licensure, one staff obtained their MLADC in May, two staff obtained their Licensed Alcohol and Drug Counselor (LADC) licensure, and an additional two staff received their Certified Recovery Support Worker (CRSW) certification. There are three staff awaiting review of their initial certificates/licenses including one LADC, and two CRSWs. They expect approval in August 2018.

All materials clinicians utilize with clients have been gathered and reviewed with a final collection of approved resources for future use. FIT-NH is working towards developing binder/electronic folder of all approved educational materials, and building policies on utilizing specific screening tools and procedures, as well as developing a policy on adding new materials for each clinical program.

FIT-NH continues the process of reviewing various screening tools and assessments for COD, and discussing the implementation and usefulness of such tools. Prior to the end of July 2018, EHR consultants will begin work on FIT-NH's EHR system to develop and implement changes to support treatment and clinical documentation of individuals with COD.

- **The Mental Health Center of Greater Manchester (MHCGM)**
  - QIP Timeline: June 2018 to May 2019
  - Anticipated Program Re-assessment: Q2 2019
  - QIP Goals:
    MHCGM has a number of goals for their staff, and assessed programs to increase the treatment capabilities for serving individuals with co-occurring disorders. Goals include increasing and standardizing educational materials that clinicians use with patients, as well as what are available in waiting areas for patients and their families. MHCGM will develop and display up to 15 rack cards with substance specific information, as well as collect existing clinician utilized resources being shared with patients (both paper and electronic copies). MHCGM has an existing Substance Misuse Committee who will review the materials, and create a Policy and educational presentation for staff in regards to what is available, their location and process for adding to the resource lists. The ultimate goal is to create numerous points of access to these resources including through a Common Drive, Staff Portal, and hard copy binders located within each program.

    MHCGM intends on supporting licensure activities for both Supervisors and staff in regards to both MH and SUD licensing/certification within the State of NH through a range of activities including recertification for existing CRSWs, weekly MLADC Supervision coverage for 4 supervisors as well as up to 8 MLADC candidates for initial licensure. License related activities for up to 10 existing MLADCs will be supported, including re-licensure obligations for both applications and Peer Collaboration. MHCGM will provide a CRSW Academy (total 48 hours, open to internal and external individuals), that includes some financial support to interested candidates.

    MHCGM is exploring new family programming curriculum (under consideration: "Recovering our Families" and "Journey of Hope"), to provide a greater range of supportive treatment options. They intend on offering a family educational series (up to 2x/annually) for up to 20 support people of existing patients. Marketing materials will be used prior to the group, and MHCGM will develop and distribute a family feedback survey to understand participant's experience and fidelity of group moving forward.

    Training for up to 30 direct care providers in Stages of Change and related COD interventions, will also be supported through MHCGM's QIP. To ensure application of skills and support is available, (up to 10) clinical staff's attendance (both in person

and through the creation of a web-based participation option) at a monthly MI (and related COD Intervention) study group.

Using their EHR, the MHCGM will develop standardized question(s) within the Supervision Form, Team Meeting Note and Cypress Center Shift notes to support ongoing use of SOC/MI skill application in individual clinical supervision. A Stage Wise assessment tool will become part of the clinical process (i.e. SOCRATES, URICA, etc.), and will be supplemented by SOC language, and specific related treatment interventions within numerous clinical notes.

Completed Activities:
To date, MHCGM has hosted a CRSW Academy (total 48 hours) in the month of June which had 17 total attendees.

A Subcommittee of the existing Substance Misuse Committee has been developed and is meeting to review all existing COD/SUD resources that clinicians are providing to clients, as well as what exists within the Staff Portal, Company Drive, and all waiting areas of programs throughout the Center. In addition, two curriculums are actively being reviewed to begin implementation of a family support and educational series for loved ones of individuals facing COD.

On an ongoing basis, clinicians are being supported through both individual and group supervision to increase and remain in good standing with related licensures and certifications relevant to treatment the COD population. Ongoing Motivational Interviewing Study Group has increased their attendance and is using their time to review, practice and brainstorm the use of effective MI strategies with clients.

Work has begun on the EMR system to amend clinical documentation to reflect the use of EBPs with the COD population including Motivational Interviewing and Stage Wise Treatment Interventions.

Pastoral Counseling Services (PCS)

- QIP Timeline: June 2018 to May 2019
- Anticipated Program Re-assessment: Q4 2019
- QIP Goals:
  PCS has a number of goals for their staff, and their Outpatient Services Program to increase the treatment capabilities for serving individuals with co-occurring disorders.

  PCS will work to develop a collection of (up to 10) resources regarding SUD and COD to display in waiting rooms and clinical office space.

  PCS will explore the use of a standardized tool to screen and assess for COD and/or SUD concerns (i.e. GAIN-SS or Q3 CAGE-AID, WHO-ASSIST etc.) as part of their clinical process. In addition, implementation of clinical SOC/MI tool(s) (i.e. Readiness Ruler, CBA, Change Plan Worksheets, etc.) will be utilized with more than 50% of all clients and documented within EHR notes.

  PCS staff will be provided with numerous training opportunities to increase knowledge and skill application in the following topics, specific the COD population: basic SOC and MI, Stigma Reduction (or similar) education (for both clinical and non-

clinical staff), and baseline training on a number of topics related to SUD including but not limited to: Provide in house basic training on SUD (including but not limited to: symptoms and recognition, PAWS, ASAM Criteria, diagnosing, treatment interventions and planning and clinical documentation, etc.). Trainings will be offered by both internal and external training resources.

In an effort to expand treatment services, PCS will support licensure efforts of their existing and initial MLADC candidates. They will work to develop a standardized Supervision format and documentation log to use during all clinical supervisions, as well as establish a monthly MLADC-led group collaboration and consultation, available for all clinical staff to attend.

PCS has a goal of expanding their treatment options including group programming aimed at individuals in services with COD. The group will be short term (8-10 sessions), for up to 8 participants. The group will be asked for feedback to understand their experience and fidelity of the group moving forward.

- Completed Activities:
  QIP activities will begin in July/August 2018

QIP Funding Review and Contracting

- 3 Dual Diagnosis Capability Quality Improvement Plans (DDC QIPs) were approved for funding (initially by the ITCOD Board, with final approval from the Network4Health Steering Committee) during the reporting period for the following organizations. The DDC QIP for Pastoral Counseling Services will be reviewed for final approval by the Steering Committee in July 2018.
  - Center for Life Management
  - Families in Transition-New Horizons
  - The Mental Health Center of Greater Manchester
- The Network4Health Steering Committee has approved the following process for the creation, review and funding approval for DDC QIPs:
  - The network partner participates in site assessment conducted utilizing evidence-based tool promoted by the Case Western Reserve University Center for Evidence Based Practice (CEBP). The tool is administered by assessors who have been trained by CEBP.
  - Results of the assessment are reviewed by the network partner, Network4Health staff and, when requested, by CEBP consultants. As part of this review, potential areas of focus for a quality Improvement plan are identified.
  - A draft Quality Improvement Plan is developed by the Co-occurring Disorders Clinical Director. The draft is presented to the network partner for consideration.
  - Final terms of a Quality Improvement Plan are developed through discussion between the network partner and the Co-occurring Disorders Clinical Director. Funding decisions are based on the scope of the work proposed and availability of budgeted funds. Final scope and funding determinations are made as a result of negotiation and agreement with the network partner.
- New Statements of Work (SOWs) were created and approved by Catholic Medical Center's Finance team to support reimbursement on behalf of Network4Health for all QIP activities for the following organizations. The SOW creation, review and approval process for DDC QIPs was new for the Network4Health and CMC Finance team. The process for these initial QIPs was lengthier than anticipated as we established the new process. Partner organizations made initial progress on their QIP activities, but have not yet been reimbursed for their progress as we await final SOWs for

signature. We anticipate the 3 QIP SOW's to be complete in July 2018 to allow for organizations to access their allocated QIP funding.

- Center for Life Management
- Families in Transition-New Horizons
- The Mental Health Center of Greater Manchester

ITCOD Training and Support for Primary Care and Community Based Organizations

Per our training plan, Network4Health sponsored the Dual Diagnosis Capability Program Leader Training on January 30th and 31st, 2018 in Manchester, NH. The two-day course was led by Richard Kruszynski, Director of Consulting and Training for the Center for Evidence Based Practice at Case Western Reserve University. 30 participants from organizations across 5 IDNs participated. 19 participants from Network4Health organizations participating in E4 project Dual Diagnosis Capability assessments attended the training.

Through this project, Network4Health is committed to providing evidence-based training for relevant components of identification and treatment for patients with co-occurring severe mental health and substance use disorders to our primary care and community support partners. The following courses were delivered during the January – June 2018 reporting period:

- Twelve participants from three Network4Health partner organizations attended the April 11-12, 2018 Adult Mental Health First Aid course delivered by Network4Health partner agency The Mental Health Center of Greater Manchester. Eight of the twelve participants represented Catholic Medical Center's primary care teams and are also participating in Network4Health's B1 Integrated Care Project.
- 71 attendees from Network4Health Partner Agencies, representing 20 different agencies attended the Initial Training on Addiction & Recovery in partnership with Region 3 (Course delivered May 10, 2018).
- 21 Correctional Officers from the Hillsborough County House of Corrections attended an Adult Mental Health First Aid course on May 1st and 3rd, 2018.

Network4Health's Co-occurring Disorders Clinical Director also began dissemination of monthly electronic and hard copy materials to support primary care and community-based support organizations interaction with and treatment of patients with co-occurring disorders. Below were topics for January – June 2018:

- January - Depression, Suicide Risk and Screening
- February - Co-occurring Disorders
- March - Bipolar and Schizophrenia
- April – Alcohol Use
- May – PTSD and Anxiety Disorders
- June - Prevention and Treatment for Substance Use Disorders

In addition to the above mentioned educational materials, the bi-yearly Spring 2018 Integrated Treatment of Co-occurring Newsletter was disseminated in hard copy to partner organizations. Topics in this issue included: project updates, educational resources and an update on the MAT project collaboration. A copy of the newsletter is available as Attachment_E4.1a.

In collaboration with partner agency Manchester City Health Department, the Network4Health Co-occurring Disorders Clinical Director was trained in Academic Detailing, as a related activity through a recent CDC grant provided through the Health Department. A total of five individuals, representing Manchester City Health Department, Catholic Medical Center and Elliot Health System, were trained in

Academic Detailing practices by the National Resource Center for Academic Detailing. Academic Detailing is an outreach education technique that combines the direct social marketing traditionally used by pharmaceutical representatives with unbiased content summarizing the best evidence for a given clinical issue. Academic Detailing is conducted with prescribers to encourage evidence-based practice in order to improve the quality of care and patient outcomes. In partnership with the Health Department, the Mental Health Center of Greater Manchester, Catholic Medical Center, Elliot Health System and Dartmouth-Hitchcock, the trained Detailing Team met with over 40 prescribers at the four provider organizations to discuss Opioid Use Disorders and treatment approaches and barriers. A special focus has been on Buprenorphine Waiver Training. The goal is to educate prescribers on best practices and available resources, in addition to encouraging prescribers to get waivered to provide Medication Assisted Treatment (MAT) as an option for patients. A local waiver training supported by Network4Health is being evaluated for interested prescribers in late August or early Fall 2018. Of the 40+ prescribers that have engaged in Academic Detailing visits, over 50% of them report an interest in becoming waivered for Buprenorphine.

Partner Outreach

The Network4Health Co-Occurring Disorders Clinical Director and Network4Health Executive Director continue to outreach to Network4Health organizations to identify additional treatment programs to be assessed utilizing the Dual Diagnosis Capability assessments for the remainder of 2018 and 2019. At this time, Catholic Medical Center's Behavioral Health Services department has tentatively agreed to participate in a Dual Diagnosis Capability assessment in the last quarter of 2018. Discussions continue with Catholic Charities and the Upper Room for potential DDC assessments in 2018.

Progress Assessment

Per our ITCOD project plan, the Network4Health Co-occurring Disorders Clinical Director held the first Integrated Treatment of Co-occurring Disorders Community of Practice meeting on June 11, 2018 with representatives from the Center for Life Management, Families in Transition-New Horizons and The Mental Health Center of Greater Manchester. The meeting focused on organizations sharing their in-progress QIP activities and future plans with other agencies and discussing any challenges or issues as they begin QIP related activities. Allocating time to work on QIP activities given significant competing initiatives, including quality improvement projects, audits, EHR implementations and upcoming physical location moves was identified by all organizations as the single greatest barrier and continued risk to progress on their QIP activities. The Community of Practice group also discussed topic ideas for future group sessions, such stage specific interventions training, and inviting more program team members to the Community of Practice meeting for knowledge sharing and educational opportunities.

Project Schedule Modifications

Due to the longer than expected QIP development timeframe, delay in QIP approval and contracting duration, DDC assessment organizations will not have completed sufficient quality improvement activities and will not be ready for a follow-up DDC assessment until Q2 2019. Network4Health has therefore updated the project plan to remove the July – December 2018 goal to re-assess up to 2 organizations between July and December 2018. Re-assessments will begin in Q2 2019. There is a project line item already in place for 2019 re-assessment activities.

An updated project plan is included as Attachment_E4.1b.

E-2. IDN Community Project: Evaluation Project Targets

Use the format below to provide a list all of the progress toward targets or goals that the program has achieved. Targets required by the STCs include, but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
The number of staff trained in identifying individuals with co-occurring conditions and referring them for treatment.	Targets will continue to be determined as part of the Dual Diagnosis Capability Quality Improvement Planning process with each participating assessment organization. **The following targets have been identified in current Quality Improvement Plans:** -Stages of Change and Motivational Interviewing Training: CLM: up to 41 staff FIT-NH: up to 14 staff MHCGM: up to 30 staff PCS: up to 20 staff (Target for 2019) -Overcoming Stigma Training: FIT-NH- up to 10 staff PCS: up to 20 staff (Target for 2019) -Substance Use Disorder Core Competencies: CLM- up to 41 staff PCS: up to 20 staff(Target for 2019)	0 - per our project plan	Overcoming Stigma: Strategies for Healthcare Professionals -FIT-NH: 23 staff – Trainings are currently being scheduled or have been scheduled for the second half of 2018 due to delays in completion and contracting for Quality Improvement Plans (QIPs).	
The number of staff trained as Program Leaders for Integrated Treatment of Co-Occurring Disorders programs.	Up to 25 in 2018	0 - per our project plan	19	

Performance Measure	Target	Progress Toward Target		
The number of organizations assessed for fidelity to evidence based practice for the integrated treatment of co-occurring disorders. The measure will include a total count of organizations assessed by the DDCAT or DDCMHT index, as well as the count of organizations by dual diagnosis capability continuum designation: • Addiction-only services (AOS) • Mental Health-only services (MHOS) • Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE)	December 2017: Up to 4 June 2018: Up to 5 December 2018: Up to 3	4 Organizations Assessed All organizations were assessed as Dual-diagnosis capable (DDC)	1 additional Organization Assessed (total 5) To date, all organizations have been assessed as Dual-diagnosis capable (DDC), however there is significant variation between organizations within the designation range.	
The number of patients served in evidence based integrated treatment of co-occurring disorders programs.	Targets are in-progress for organizations that have recently completed Quality Improvement Plans	0 - per our project plan	0 – due to delays in completion and contracting for Quality Improvement Plans, organizations will be submitting this information for the January 2019 Semi-Annual Report	

E-3. IDN Community Project: Workforce Staffing

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

There has been no change in staffing during the January – June 2018 reporting period.

Provider Type	IDN Workforce (FTEs)				
	Projected Total Need	Baseline Staffing on 6/30/17	Staffing on 12/31/17	Staffing on 6/30/18	Staffing on 12/31/18
Co-occurring Disorders Clinical Director	Up to 1	0	1	1	
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	4 Per diem DDC Assessors	4 Per diem DDC Assessors	

E-4. IDN Community Project: Budget

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

The Integration of Co-occurring Disorders Treatment budget is presented below. Modifications have been made based on several factors:

Revenue- All project budgets have been adjusted to reflect the actual receipt or availability of future funding. Previously, our budgets were developed utilizing revenue projections based on the time period for which they could be earned. Revenue for 2018 is being reported in two new columns. The first identifies the actual incentive funding received in May for the July to December 2017 reporting period. It represents a partial payment with the remainder expected soon. The second column, for 2018, projects the receipt of the remaining prior period incentive funding as well as incentive funding anticipated for November. N4H has also added a column for the period of January to June 2021 as we have been informed that our final potential incentive payment would be expected in May or June of 2021.

Expenses- Actual expenses (paid and invoices received) for the period of January to June of 2018 are presented. Anticipated expenses (including those for January to June not yet invoiced) are presented in the column reflecting July to December 2018. Given that final incentive funding is not expected to be received until May or June of 2021, we have projected expenses in that period as we conclude the waiver projects.

Reported actual expenses continue to be below budget due in part to expense reporting including only invoiced and paid expenses. Another significant factor has been the delay of finalizing Services Agreements and other legal documentation needed for disbursing funds to network partners who are implementing approved Quality Improvement Plans. This issue is anticipated to be resolved soon.

TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual	CY 2018 (Yr3) January to June Actual	CY 2018 (Yr3) July to December Projected	CY 2019 (Yr4) Projected	CY 2020 (Yr5) Projected	CY 2021 (Yr6) Projected
E4 INTEGRATED TX COD Revenue (New)	$ 230,012	$ 128,807	$ 331,217	$ 460,024	$ 468,542	$ 238,530
E4 INTEGRATED TX COD Revenue (Rollover)		$ 221,683	$ 335,984	$ 189,360	$ 100,306	$ 429
Total Revenue	$ 230,012	$ 350,490	$ 667,201	$ 649,384	$ 568,848	$ 238,959
Dual Diagnosis Capability Assessor Participation Offset (Training and Assessment Time)	$ 6,848	$ 2,970	$ 61,791	$ 50,563	$ 50,563	
Dual Diagnosis Capability Program Leader Training (2018) Attendee Participation Offset		$ 2,640	$ 23,100			
Dual Diagnosis Program Leader Training (2019) and Attendee Participation Offset				$ 22,659		
Co-Occurring Disorders Capability Quality Improvement Plan Funds			$ 350,000	$ 434,000	$ 476,000	$ 216,000
N4H Assessor Training Course Development and Delivery			$ 5,250	$ 3,150	$ 3,150	$ 3,150
Integrated Treatment Tools & Training for Primary Care and Community Support Organizations		$ 7,801	$ 35,000	$ 35,000	$ 35,000	$ 17,500
Technology (Laptop, Phone, etc.)	$ 1,218	$ 439	$ 1,694	$ 1,694	$ 1,694	$ 1,694
Occupancy	$ 263	$ 656	$ 1,006	$ 2,012	$ 2,012	$ 1,016
Subtotal	$ 8,329	$ 14,506	$ 477,841	$ 549,078	$ 568,419	$ 239,360
Variation to Budget (Transfer Funds to Subsequent Year)	$ 221,683	$ 335,984	$ 189,360	$ 100,306	$ 429	$ (401)

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

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

Serenity Place has been removed from our list of key organizational and provider participants since our January 2018 Semi Annual Report. As of January 23, 2018, the court ordered the liquidation of Serenity Place's assets and programs. The Wellness Re-integration Action Plan (WRAAP) program that was assessed using the DDCAT tool was not transitioned in its entirety to a new partner organization. Network4Health continues to work with partner organizations to evaluate how transitioned Serenity Place programs can be supported by the project.

Pastoral Counseling Services, with offices in Manchester, was added to our list of project participants and, as described in our project narrative, has completed a DDCMHT assessment of their Outpatient Therapy Services.

Organization/Provider	Agreement Executed (Y/N)
Mental Health Center of Greater Manchester (MHCGM)	Y
Center for Life Management	Y

Organization/Provider	Agreement Executed (Y/N)
Families in Transition – New Horizons (FIT-NH)	Y
Pastoral Counseling Services	Y

E-6. IDN Community Project: Standard Assessment Tools

Use the format below to identify and briefly describe the Assessment and Screening tool(s) that will be developed and/or used for the IDN Community Project

The list of assessment tools below includes all tools approved for use by the Network4Health ITCOD project team. The Network4Health ITCOD team has added the CAAPE-5 as an additional evidence based diagnostic tool that is currently under review for use by the Family Willows program at Families in Transition-New Horizons. The SOCRATES 8A and 8D have also been added as tools that support the use of stages of change and motivational interviewing treatment practices. These are currently under review for use as part of the Quality Improvement Plan for the Mental Health Center of Greater Manchester.

As previously indicated, the team does not intend to dictate to network providers that all tools must be used. During organizational assessments and the creation of a Quality Improvement Plan, Network4Health providers will continue to select specific assessments that are pertinent to their Quality Improvement Plan and treatment of patients with co-occurring disorders.

Standard Assessment Tool Name	Brief Description
Dual Diagnosis Capability in Addiction **Treatment (DDCAT) Index** **Organizational Assessment Tool**	The DDCAT index is designed to determine how effectively substance use treatment programs provide services for patients with co-occurring mental health disorders. The index is comprised of 35 items that explore an organization's policies, clinical practices, and workforce capacities (e.g., staff education, training, licensure, experience, availability). These items are organized into seven domains that include the following: • Program structure • Program milieu • Clinical practice/assessment • Clinical practice/treatment • Continuity of care • Staffing • Training Consultants review and score the data they have collected with the indexes and categorize the organization along a continuum of capability. The continuum for addiction-service organizations assessed with the DDCAT index includes: • Addiction-only services (AOS) • Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE) The index is recognized as a reliable and valid tool for assessing outpatient, residential and hospital-based treatment programs (Gotham, Brown, Comaty, Joseph E., McGovern, & Claus, 2013). An important purpose of the DDCAT evaluation process is to encourage treatment programs to improve every aspect of their care.
Dual Diagnosis Capability in Mental Health **Treatment (DDCMHT) Index** **Organizational Assessment Tool**	Similar to the DDCAT, the DDCMHT index is designed to determine how effectively mental health treatment programs provide services for patients with co-occurring substance use disorders. The DDCMHT utilizes the same 35 items across the 7 domains described above for DDCAT and organizations are scored across the following continuum of capability. • Mental-health-only services (MHOS) • Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE)

Standard Assessment Tool Name	Brief Description
The Mental Health Screening Form-III (Assessment/Screening)	Screening assessment for clients seeking SUD treatment to identify any co-occurring disorders. (SAMHSA TIP 42)
Simple Screening Instrument for Substance Abuse (SSI-SA) **(Assessment/Screening)**	Designed for use within a clinical setting for clients receiving or seeking treatment and for administration and use under the standard conditions found in most substance abuse and/or mental health clinics. (SAMHSA TIP 42)
PHQ-9 Depression Screening **(Assessment/Screening)**	The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
PHQ-2 Depression Screening **(Assessment/Screening)**	The PHQ-2, comprising the first 2 items of the PHQ-9, inquires about the degree to which an individual has experienced depressed mood and anhedonia over the past two weeks. Its purpose is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.
Generalized Anxiety Disorder Screening (GAD 7) **(Assessment/Screening)**	Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder (GAD).
Addiction Severity Index (ASI) **(Assessment/Screening)**	The ASI is a general screening tool used extensively for treatment planning and outcome evaluation. (SAMHSA TIP 42)
Alcohol Use Disorders Identification Test (AUDIT) **(Assessment/Screening)**	The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health. The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alco hol involvement. (SMHSA TIP 42)

Standard Assessment Tool Name	Brief Description
Beck Depression Inventory–II (BDI–II) **(Assessment/Screening)**	Used to screen for the presence and rate the severity of depression symptoms. The BDI–II consists of 21 items to assess the intensity of depression. The BDIII can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. (SAMHSA TIP 42)
CAGE and CAGE-AID **Questionnaire** **(Assessment/Screening)**	The purpose of the CAGE Questionnaire is to detect alcoholism. CAGE-AID detects alcoholism and drug use. The CAGE Questionnaire is a useful bedside, clinical desk instrument. It is a very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present. (SAMHSA TIP 42).
Circumstances, Motivation, and Readiness Scales (CMR Scales) **(Assessment/Screening)**	SAMHSA TIP 42 The instrument is designed to predict retention in tre atment and is applicabl to both residential and outpatient treatment modalities. The instrument consists of four derived scales measuring external pressure to en ter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment.
Clinical Institute Withdrawal Assessment (CIWA-Ar) **(Assessment/Screening)**	Converts DSMIIIR items into scores to track severity of withdrawal; measures severity of alcohol withdrawal. Aid to adjustment of care related to withdrawal severity. (SAMHSA TIP 42)
Drug Abuse Screening Test (DAST) **(Assessment/Screening)**	The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and mis-use. Screening and case finding: Level of treatment and treatment/goal planning. (SAMHSA TIP 42)

Standard Assessment Tool Name	Brief Description
Global Appraisal of Individual Needs (GAIN) or GAIN SS - Short Screener **(Assessment/Screening)**	The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling. (SAMHSA TIP 42)
Level of Care Utilization System (LOCUS) **(Assessment/Screening)**	To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time. (SAMHSA TIP 42)
Michigan Alcoholism Screening Test (MAST) **(Assessment/Screening)**	Used to screen for alcoholism with a variety of populations. (SAMHSA TIP 42)
M.I.N.I. Plus **(Assessment/Screening)**	Assists in the assessment and tracking of patients with greater efficiency and accuracy. (SAMHSA TIP 42)
Psychiatric Research Interview for Substance and Mental **Disorders (PRISM)** **(Assessment/Screening)**	The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and co-occurring disorder treatment samples. (SAMHSA TIP 42)
Readiness to Change Questionnaire **(Assessment/Screening)**	Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders. (SAMHSA TIP 42)
Recovery Attitude and Treatment Evaluator (RAATE) **(Assessment/Screening)**	Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge. (SAMHSA TIP 42)
Structured Clinical Interview for DSM-IV Disorders (SCID-IV) **(Assessment/Screening)**	Obtains Axis I and II diagnoses using the DSMIV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of “drug abuse” or “drug dependence” and/or “alcohol abuse” or “alcohol dependence.” (SAMHSA TIP 42)
Substance Abuse Treatment Scale (SATS) **(Assessment/Screening)**	To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder. (SAMHSA TIP 42)

Standard Assessment Tool Name	Brief Description
University of Rhode Island Change Assessment (URICA) **(Assessment/Screening)**	The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items. (SAMHSA TIP 42)
Clinical Opiate Withdrawal Scale (COWS) **(Assessment/Screening)**	The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Assessment/Screening)	Evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Promoted by SAMHSA and US Preventive Services Task Force
PHQ-A **(Assessment/Screening)**	Identifying depression in adolescents 11-17
Brief Psychiatric Rating Scale (BPRS) **(Assessment/Screening)**	A rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behavior. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored.
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) **(Assessment/Screening)**	Screening to detect and manage substance use and related problems in primary and general medical care settings
Comprehensive Addictions And Psychological Evaluation-5 (CAAPE-5)	The CAAPE-5 is a comprehensive diagnostic assessment interview providing documentation for substance-specific diagnoses based on DSM-5 criteria.
SOCRATES 8A(alcohol) or 8D(drugs) Stages of Chain Readiness and Treatment Eagerness Scale	A 19 item instrument designed to assess readiness to change in substance users.

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

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

The chart below includes examples of evidence-based treatment protocols for patients with co-occurring disorders. **Based on review of current protocols used with partner organizations participating in the dual diagnosis capability assessments, Network4Health will provide partners with recommended protocols for assessment and referral of patients with co-occurring disorders during the second half of 2018.**

As noted through the completed DDCAT/DDCMHT organizational assessments, the ITCOD team has added Medication Assisted Treatment and Peer Supports as currently used evidence-based Treatment and Management protocols for the co-occurring disorders population.

Protocol Name	Brief Description	Use (Current/Under Development)
Integrated Treatment for Co-Occurring Disorders (formerly IDDT) **(Treatment)**	Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery	Current
Multidisciplinary Team **(Treatment)**	The service team may include the following roles: Team Leader, Nurse, Case Manager, Employment Specialist, SA Specialist, Housing, Counselor, Criminal Justice, and Physician/Psychiatrist. Th e list is not exclusive and may include additional roles as required for a client.	Current
Stage-Wise Interventions **(Treatment)**	Consumers recovering from substance use disorders and serious mental illnesses go through stages, each of which marks readiness for a specific treatment. Integrated treatment specialists must assess consumers' stage of treatment and tailor services accordingly: Engagement, Persuasion, Active Treatment, Relapse Prevention	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Motivational Interventions (Treatment)	Motivational interventions include motivational interviewing, motivational counseling, and motivational treatment. These interventions help consumers identify personal recovery goals.	Current
Supported Employment (Treatment)	Motivational interviewing helps consumers identify their goals for daily living, as well as strategies (activities) for achieving those goals.	Current
Assertive Community Treatment (Treatment)	Successful integrated treatment of COD programs utilize assertive outreach to keep clients engaged in relationships with service providers, family members, and friends.	Current
Assertive Outreach (Treatment)	Service providers who utilize assertive outreach meet with consumers in community locations that are familiar to consumers, such as in their homes or at their favorite coffee shops or restaurants.	Current
Substance Abuse Counseling (Treatment)	Counseling that provides recovery skills	Current
Group Treatment (Treatment)	Research indicates that individuals with co-occurring disorders achieve better outcomes when they engage in stage-wise group treatment that addresses both disorders.	Current
Self Help Groups (Treatment)	Self-help groups are excellent sources of social support for individuals who are motivated to achieve and maintain abstinence.	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Family Psychoeducation (Treatment)	Family psychoeducation fosters social support. It includes consumers, caregivers (family members and friends), and service providers in the treatment process.	Current
Pharmacological Treatment (Treatment)	Medications are effective in the treatment of persons with severe mental illness and co-occurring disorders. Medications generally include the following: Antipsychotics, Mood stabilizers and Antidepressants	Current
Medication Assisted Treatment (Treatment)	Medicated-Assisted Treatment (MAT) is the use of FDA- approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.	Current
Interventions to Promote Health (Treatment)	Research indicates that individuals with co-occurring disorders are at increased risk for poor health. Treatment team members encourage consumers to live healthy lifestyles	Current

Protocol Name	Brief Description	Use (Current/Under Development)
Peer Supports (Management)	Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. The shared experience of being in recovery from a mental health and/or substance use condition or being a family member is the foundation on which the peer recovery support relationship is built in the behavioral health arena	Current

E-8. IDN Community Project Member Roles and Responsibilities

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

DHHS reserves the right to audit all or a selection of the written Roles and documents used by the IDNs.

Network 4 Health Integrated Treatment of Co-occurring Disorders (ITCOD) Project Advisory Board: Many of the dedicated planning phase partner organizations have agreed to remain with the ITCOD as members of the ITCOD Project Advisory Board. The Project Advisory Board will monitor progress on project activities, milestones and data reporting. The team will also be the funding approval mechanism for the Co-occurring Disorders Quality Improvement Plans for each organization participating in the DDCAT/DDCMHT organization assessments. The Advisory Board will provide strategic input to project barriers, issues, risks and project re-alignment when required. The team will meet quarterly to follow project progress and as needed for approval of Quality Improvement Plans.

Network 4 Health Dual Diagnosis Capability (DDC) Assessment Team: Network4Health developed a Dual Diagnosis Capability (DDC) Assessment Team using experienced clinical and supervisory staff members currently working within our partner organizations. Per diem members of the DDC Assessor Team include individuals who are employed by the Center for Life Management, Catholic Medical Center Behavioral Health and the Mental Health Center of Greater Manchester. The team is led by the

Network4Health Co-occurring Disorders Clinical Director. As reported previously in 2017, 5 team members including the Co-occurring Disorders Clinical Director were trained as DDCAT/DDCMHT Assessors. The team continues to work together to provide DDCAT and DDCMHT assessments to participating organizations and has been receive consultative support from the dual diagnosis capability experts at Case Western Reserve University's Center for Evidence Based Practices throughout the Assessment and QIP Development process.

Integrated Treatment of Co-occurring Disorders (ITCOD) Practice Improvement Community:
Organizations participating in the Network4Health DDCAT/DDCMHT assessment process are asked to join bi-yearly meetings of the Network4Health ITCOD Practice Improvement Community. The group is a platform to share the ongoing dual diagnosis capability quality improvement efforts and identify increased opportunities for shared learning. The following project members participated in the first Community of Practice meeting in June 2018:

Team Member	Organization
[redacted]	The Mental Health Center of Greater Manchester
[redacted]	The Mental Health Center of Greater Manchester
[redacted]	The Mental Health Center of Greater Manchester
[redacted]	The Mental Health Center of Greater Manchester
[redacted]	The Mental Health Center of Greater Manchester
[redacted]	The Mental Health Center of Greater Manchester
[redacted]	Families in Transition – New Horizons
[redacted]	Families in Transition – New Horizons
[redacted]	Center for Life Management
[redacted]	Network4Health
[redacted]	Network4Health

Modifications
Melissa Crews has replaced Brian Mooney as the representative from Hope for NH Recovery. The following Network4Health ITCOD Advisory Board Members who have participated on the team during the reporting period:

Project Team Member	Roles and Responsibilities
[redacted] Network 4 Health/Mental Health Center of Greater Manchester	Co-Occurring Disorders Clinical Director, Network4Health Provides clinical and subject matter leadership for the activities of the project. Works with all network partners to assure enhanced identification of individuals who experience co-occurring disorders, referral to needed services and capacity for care delivery that utilizes evidence based and best practice approaches to care.
[redacted] Network 4 Health/Mental Health Center of Greater Manchester	Project Manager, Network4Health Monitors project activities and schedule. Supports scheduling of trainings, meetings and other project related events as required. Responsible for project status reporting to the ITCOD Project Advisory Team, Steering Committee and DHHS.
[redacted] Mental Health Center of Greater Manchester (MHCGM)	Co-lead, ITCOD Project Advisory Team See ITCOD Project Advisory Team description above. Integrated Treatment of Co-occurring Disorders (ITCOD) Practice Improvement Community: See description above

Project Team Member	Roles and Responsibilities
[redacted] Center for Life Management	Co-lead, ITCOD Project Advisory Team: See ITCOD Project Advisory Team description above. Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above DDC Primary Care and Support Team Member: See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team
[redacted] MHCGM	Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above
[redacted] MHCGM	Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above
[redacted] Catholic Medical Center (CMC)	Dual Diagnosis Capability Assessor: See Dual Diagnosis Capability Assessment Team above ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted] Granite Pathways	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above. DDC Primary Care and Support Team Member: See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team
[redacted] The Upper Room	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted], Elliot Health System	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted], Parkland Medical Center	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.
[redacted], Hope for NH Recovery	ITCOD Project Advisory Team Member: See ITCOD Project Advisory Team description above.

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

A list of participants for completed trainings is included in Attachment_E4.9

Completed Trainings

The following Network4Health trainings were completed between 1/1/2018 and 6/30/2018.

Training or Training Related Activity	Participants	Completion Progress
DDCAT/DDCMHT Assessment Capacity Development		
Deliver Up To 30 Hours DDCAT/DDCMHT Consulting (Provided by CEBP) • These hours are available to the Dual Diagnosis Capability Assessor team for support and continued learning around	1	[redacted] utilized approximately 11 hours of time in monthly sessions with a consultant from Case Western Reserve University.

Dual Diagnosis Capability Program Leaders Training [redacted] from Case Western Reserve University's Center for Evidence Based Practice (CEBP) delivered a 2 day in-person training on January 30th and 31st in Manchester, NH to provide supervisors and program managers with the opportunity to familiarize themselves with the DDCAT/DDCMHT indices and the planning and implementation processes associated with each. Participants in this training also learned about the implications of DDCAT/DDCMHT for supervising improved treatment strategies and models of care for individuals with co-occurring mental illness and substance use disorders. A total of 30 individuals attended the Program Leader Training. For Network4Health, there were 19 individuals representing 7 of our partner agencies. The remaining attendees represented Regions 1, 3, 5 and 6.	19 from IDN 4 30 total from IDNS, 1, 3, 4, 5 and 6	Completed 1/30/2018 – 1/31/2018

Co-occurring Disorders Education for Primary Care Providers
 	
Every month, both hard copies and electronic links are sent to all Network4Health partners, providing access to materials and education surrounding the co-occurring population. All materials are sent out prior to the last day of the month. Materials thus far have focused on the following topics:
 	
• **January: Depression and Suicide Risk**
  ○ Fact Sheet(s)-: Depression, Suicide and Depression for Caregivers. Brief overview of what each disorder is including symptoms, treatment and self-help resources.
  ○ Emergency Department Suicide Risk Assessment Poster
  ○ Suicide Primer for PCP Offices: A booklet designed to provide basic information about suicide risk and assessment for healthcare settings.
  ○ Columbia Suicide Screeners (including: Corrections, Pediatric and Cognitively Impaired, Primary Care and Recent (with an additional "Recent with SAFE-T Protocols)
	Disseminated to representatives from all Network4Health partners	Completed January 2018

Co-occurring Disorders Education for Primary Care Providers • **February: Co-Occurring Disorders** ○ Talking with Adult Patients about Alcohol, Drug and/or Mental Health Problems: A Discussion Guide for Primary Health Care Providers: A brief guide for healthcare practitioners on how to identify, support and refer individuals with co-occurring (mental health and substance use) disorders.	Disseminated to representatives from all Network4Health partners	Completed February 2018

○ Fact Sheet- Dual Diagnosis: Brief overview of what dual diagnosis/co-occurring disorders are including symptoms, treatment and self-help resources. ○ "Language of Recovery": Language suggestions for working co-occurring disordered individuals to reduce stigma and offensive terms. ○ "Tools and Interventions for Working with People with Co-Occurring Disorders": List of common obstacles and solution to working with this population as well as a list of common consequences of substance use. ○ "Motivational Interviewing Strategies and Techniques…" Brief overview of Motivational Interviewing skills, to help increase self-empowerment for consumers as well as increase effective communication skills for provider. ○ "Am I Doing this Right" poster: Quick guide for practitioners to increase their Motivational Interviewing Skills when communicating. ○ TICS and CAGE-AID: TICS is a two item screen administered by provider for alcohol and other drug use for adolescents and adults in a medical setting. CAGE-AID is a four item screen administered by provider or self-report, for alcohol and other drug use for adolescents and adults in a medical setting. ○ "Change Plan Worksheet": A self-led worksheet for patients to help them understand and implement desired changes.		
Co-occurring Disorders Education for Primary Care Providers • **March: Bipolar and Schizophrenia** ○ Fact Sheets (English and Spanish) Schizophrenia and Bipolar Disorder(s): Brief overview of disorders including symptoms, treatment and self-help resources. ○ Booklet on Early Psychosis: Numerous handouts detailing early psychosis including symptoms, how to help and support individuals and treatment options. ○ Resource Guide for Caregivers (Early Psychosis): Booklet designed to provide education, support and resources to support people of individuals experiencing early psychosis. ○ YouTube video simulation of auditory hallucinations ○ Child/adolescent Bipolar Disorder: Brochures designed to provide education, support and resources to the caregivers of children and adolescents experiencing the symptoms of Bipolar Disorder.	Disseminated to representatives from all Network4Health partners	Completed March 2018
• **April: Alcohol Awareness**	Disseminated to	Completed April

○ Alcohol Awareness Bulletin: A brief guide for clients/patients containing alcohol education and resource links. ○ Alcohol Withdrawal Fact Sheet: Brief overview of alcohol withdrawal syndrome including related symptoms, diagnostic criteria and Prediction of Alcohol Withdrawal Severity Score (PAWSS). ○ Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar): Clinical Scale used to gauge current client alcohol withdrawal symptoms. ○ AUDIT: Brief description of Alcohol Use Disorders Identification Test, including interview and self-report versions. ○ Recovery Resource Guide: Booklet developed and distributed by NH Bureau of Drug and Alcohol Services. This guide lists state- funded recovery community centers throughout the state, as well as a general description of services available at peer support agencies. ○ Addressing Co-Occurring Disorders in Non-Traditional Service Settings: Overview paper that provides education and suggestions to agencies that do not identify as behavioral health or substance use disorder agencies, on how to identify and provide support to the co-occurring disordered population.	representatives from all Network4Health partners	2018
Co-occurring Disorders Education for Primary Care Providers • **May: Anxiety and PTSD** ○ Anxiety and PTSD Fact Sheets: Brief overview of what Anxiety Disorders and PTSD are including symptoms, treatment and self-help resources. ○ "PTSD Treatment Works": Brief overview of PTSD related treatments available and how to access. ○ "Sound Familiar?" Poster about possible side effects of anti-anxiety related medications for PTSD. ○ PTSD Checklist (PCL-C): Abbreviated version of the PTSD Checklist (Civilian Version). Developed for use in Primary Care and/or similar medical settings. Screening Tool used to identify presence and intensity of PTSD related symptoms. ○ Generalized Anxiety Disorder Screener (GAD-7): Clinical Screener used to identify symptoms commonly associated with Anxiety Disorders. ○ "Primary Care: The best PTSD care anywhere starts with you": Brief description Brief fact sheet and suggestions for healthcare providers in working with patients who are diagnosed with PTSD. ○ "Understanding Anxiety Disorders": Resource Guide for Caregivers: Guide for Caregiver's of individuals diagnosed with an Anxiety Disorder. Describes	Disseminated to representatives from all Network4Health partners	Completed May 2018

symptoms, treatments, and how to get and give support. o SAMHSA TIP 57: Trauma Informed Care in Behavioral Health Service (Abridged Compilation): Overview of important points from TIP 57 including trauma recognition, responses and co-occurring disorders.		
Co-occurring Disorders Education for Primary Care Providers • **June: Prevention and Treatment** o Prevention Resource Guide: Booklet developed and distributed by NH Bureau of Drug and Alcohol Services. This guide lists state- funded recovery community centers throughout the state, as well as a general description of services available through Prevention agencies. Treatment Resource Guide: Booklet developed and distributed by NH Bureau of Drug and Alcohol Services. This guide lists state- funded recovery community centers throughout the state, as well as a general description of services available at numerous treatment agencies	Disseminated to representatives from all Network4Health partners	Completed June 2018
Mental Health First Aid Training (8 hour training, maximum of 25 participants per course) **When:** April 11 and 12, 2018 **Where:** Manchester/Wall St **Trainer:** [redacted] and [redacted]	# of Network4Health Partner Organizations: 3 # of Network4Health Participants: 12	Completed April 11 and 12, 2018
Mental Health First Aid Training (8 hour training, maximum of 25 participants per course) **When:** May 1 and 2, 2018 **Where:** Hillsborough County Department of Corrections **Trainer:** [redacted] and [redacted]	# of Network4Health Partner Organizations: 1 # of Network4Health Participants: 21	Completed May 1 and 2, 2018
Introduction to Addiction & Recovery When: May 20, 2018 Where: Manchester /Derryfield Trainer: [redacted]	# of Network4Health Partner Organizations: 16 (Region 4) and 11(Region 3) # of Network4Health Participants: 58	

	(Region 4) and 20 (Region 3)	
IHI Webinar Series: Virtual Expedition: Taking on the Opioid Crisis". A web-based training series that was offered as a single web/phone connection for a team to view together. Network4Health offered one web/phone connection per organization. This IHI Virtual Expedition is approved for a total of 5 continuing education credits for physicians, nurses and pharmacists.	# of participating Network4Health Partner Organizations: 2 # of participants completing the series: 5	Complete on (multiple dates) February 28, March 14, March 28, April 11 and 18, 2018
Stigma Training	# of participating Network4Health Partner Organizations: 1-Families in Transition-New Horizons # of participants: 24	June, 2018

Training Plan (Future Trainings)

In addition to our use of CEBP services, Network4Health will continue to promote and expand training services currently available within our partner organizations. Below table provides the trainings that are currently scheduled, though additional trainings may be added to support Quality Improvement Plans or identified need for our partners.

Training or Training Related Activity	Participants	Scheduled Or To be Scheduled by…	Completion By…
DDCAT/DDCMHT Assessment Capacity Development			
Deliver Up To 30 Hours DDCAT/DDCMHT Consulting (Provided by CEBP) - These hours are available to the Dual Diagnosis Capability Assessor team for support and continued learning around	Up to 5	Monthly sessions scheduled with Case Western Reserve University, Center for Evidence Based Practice Consultant	12/28/2018 11 Hours used as of June 30, 2018
Quality Improvement Plan Related Trainings			

Stages of Change and Motivational Interviewing Training (Center for Life Management)	Up to 41	October, 2018	12/31/2018
Stages of Change and Motivational Interviewing Training (Families in Transition – New Horizons)	Up to 14	September, 2018	12/31/2018
Stages of Change Training (Mental Health Center of Greater Manchester)	Up to 30	To be scheduled	12/31/2018
Substance Use Disorder Training (Center for Life Management)	Up to 41	To be scheduled	12/31/2018
Stages of Change and Motivational Interviewing Training (Pastoral Counseling Services)	TBD	To be scheduled	5/31/2019
Substance Use Disorder Training (Pastoral Counseling Services)	TBD	To be scheduled	5/31/2019
Overcoming Stigma Training (Pastoral Counseling Services)	TBD	To be scheduled	5/31/2019
Primary Care and Support Organization Development			
Co-occurring Disorders Education for Primary Care Providers and Support Organizations • Dissemination of hard copy materials • Topics include: Co-occurring Disorders, Depression and Suicide Risk, Schizophrenia and Bipolar Disorder, Alcohol Use, PTSD and Anxiety Disorders, Wellness, Personality Disorders, Opioid Use Disorders, Children and Adolescents Co-Occurring Disorders, Geriatric Patients with Co-Occurring Disorders	All primary care provider practices and support organizations	Disseminated by the last day of each month in 2018	Materials disseminated monthly on a selected topic (see list in title) 1/2018-6/2018 Complete 7/2018-12/2018 Scheduled

Mental Health First Aid Training (8 hour training, maximum of 25 participants per course)	Up to 10 primary care or community support organizations	A minimum of 1 training will be offered each quarter starting in April 2018 Scheduled: September 5/6, 2018 and September 21/28, 2018	December 31, 2018
Lunch and Learns to support additional education of primary care and community support organizations around patients with co-occurring disorders and tools for their identification and treatment **Scheduled events include:** • Motivational Interviewing: Overview of history, theory, strategies and implementation within a clinical setting • Co-Occurring Disorders: Overview of definition, special considerations, assessment and treatment of COD population.	Up to 50 attendees	Scheduled: November 2018 Scheduled: August and October 2018	December 31, 2018
American Society of Addiction Medicine(ASAM) Levels of Care Webinars • Providers learn about ASAM Criteria and treatment levels that determine medical necessity determinations, recent diagnostic changes to ASAM criteria; and treatment planning for individuals with Substance Use Disorders.	Up to 50 attendees	Scheduled: October 15, 2018 and October 24, 2018	October 2018
Training Event Seats to support additional education of primary care and community support organizations around patients with co-occurring disorders and tools for their identification and treatment	Up to 160 seats for primary care or community support organizations	Seats will be offered through 2018 as trainings become available.	December 31, 2018

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				

Integrated Treatment of Co-Occurring Disorders Newsletter

Spring 2018

Topics in This Issue:

Project Overview and Updates 1

Dual Diagnosis Capability Assessments and Updates 2

Primary Care and Support Organization education and resources 2

MAT Project collaboration 3

Thank you for reading!

[redacted], *LICSW, MLADC*
Director of Integrated Treatment of Co-Occurring Disorders

Overview and Updates

The ITCOD Project, through the 1115 Waiver has two essential goals:

- To provide education and training activities that meet the needs of organizations who frequently work with patients with co-occurring disorders, but are not the primary mental health or substance use disorder treatment providers.
- Utilizing a team of New Hampshire-based subject matter experts, provide Program Level Assessments for primary behavioral health and substance use disorder treatment facilities. The Assessor Team helps Network4Health organizations increase their dual diagnosis capabilities through the formal DDCAT/DDCMHT Assessment, and a resulting Quality Improvement Plan.

What we have accomplished so far…

**Three Quality Improvement Plans developed, approved for funding and in Implementation Phase!*

**One new organizational assessment completed by ITCOD Assessor Team, including creation and delivery of DDCMHT final report (QIP development in progress)*

**Three in person trainings hosted for PCP and Support Organizations*

**Six monthly mailings delivered to 84 contacts at 43 different Network Partner Agencies*

**Collaboration with Health Department for CDC grant on Academic Detailing Project regarding MAT*

**Held first bi-annual Community of Practice Meeting for agencies that have participated in the DDCAT/DDCMHT Assessment process*

Quality Improvement Plan Implementation has started for the first three agencies that completed their Dual Diagnossis Capability Assessments! Center for Life Management, (CLM), Mental Health Center of Greater Manchester (MHCGM), and Families in Transition (FIT-NH) are working within their own agencies on the following areas to increase their capability to serve the co-occurring disordered population. *All focus areas and activities were idenitified as a result of their DDCAT/DDCMHT assessment reports.*

FOCUS AREA	PLANNED ACTIVITIES
Increasing family and group programming	Family Education, Client Recovery Group
Baseline training/knowledge expectations for all staff (new and existing)	Staff trainings including: Motivational Interviewing, Stages of Change, Core Competencies, ASAM
Providing increased resources within client waiting areas and common spaces	Pamphlets, brochures, rack cards, posters, booklets
Supporting staff efforts to obtain NH licensure(s)	Supervisory training and ongoing support to help clinicians implement learned skills
Increasing and standardizing Screening and Assessment process using validated measures	EHR/EMR adjustments to document clinical work and interventions used with COD patients/clients
Increasing peer support connections	CRSW Academy to increase available peers within the workforce

The Assessor Team continues to speak with partners in our Region to encourage participation in the DDCAT/DDCMHT Assessment process and looks forward to the new site assessment prospects for the coming year!

PCP and Support Organization Resources and Education

Initial Training on Addiction, held at the Derryfield

✓Three in person trainings hosted for PCP and Support Organizations

MENTAL HEALTH FIRST AID (MHFA):

*Hillsborough County House of Corrections : *21 attendees (all Correctional staff including ranks of Sergeants, FTOs (Field Training Officers) and Correctional Officers, with a range of experience from 2-17 years)!*

*Open to all Partners: *12 attendees, representing 3 agencies!*

INITIAL TRAINING ON ADDICTION:

*In conjunction with Region 3 (Nashua) and DHHS)- *71 attendees total with 53 attendees being from IDN 4, representing 20 N4H Partner Agencies!*

UPCOMING POSSIBILITIES:

**MAT (Medication Assisted Treatment) Buprenorphine Waiver Training for Prescribers*

**MHFA for additional staff at the Hillsborough County House of Corrections as well as Crotched Mountain*

✓Monthly resources provided to 84 contacts at 43 different locations

TOPICS ADDRESSED TO DATE:

Depression and Suicide Risk Assessment and Support, Bipolar, Schizophrenia, Co-Occurring Disorders, PTSD, Anxiety Disorders, Alcohol Use Disorders

INTERESTED IN A SPECIFIC TOPIC OR RESOURCE REGARDING CO-OCCURRING DISORDERS? EMAIL SAWYERKA@MHCGM.ORG

Academic Detailing and Medication Assisted Treatment

Manchester Health Department received a grant from the CDC to explore, plan, and implement innovative and collaborative approaches to support efforts to combat the opioid crisis within our community. Being one of four chosen sites within the United States, Manchester is unique in our approach of grant fund usage.

This Centers for Disease Control and Prevention (CDC) funded project aims to increase the capacity of local health departments (LHDs) to respond effectively to the opioid epidemic by working more closely with state and local partners (e.g., law enforcement, healthcare providers, local/state health departments) and rolling out evidence-based strategies at the local level.

Through a two day training led by NarCAD (National Resource Center for Academic Detailing), five people were trained in Academic Detailing. Detailers include employees of Network4Health (both Elliot and MHCGM), CMC and Manchester Health Dept. Since being trained, the detailers have spoken to almost 40 prescribers at Partner agencies! Through the project we have been able to share and gather information from prescribers about the challenges and rewards in working with people during their recovery journey.

The detailers are excited to share that there has been a great interest from prescribers, in becoming waivered to prescribe Buprenorphine (Suboxone); increasing available treatment options for people looking to address their substance use disorder(s)!

Stay tuned for more information on a local MAT Waiver training being planned for early Fall!

Attachment_E4.1a

Attachment_E4.1b

E4-ITCOD-072018

	Task Name	Duration	Start	Finish	Predecessors	% Complete
1	**N4H: Integrated Treatment of Co-occurring Disorders Implementation**	936d	06/30/17	01/29/21		29%
2	**Workforce Plan**	126d	07/03/17	12/25/17		100%
3	Recruit N4H Co-Occurring Disorders Clinical Director	126d	07/03/17	12/25/17		100%
4	Recruit N4H DDCAT/DDCMHT Assessors	45d	07/03/17	09/01/17		100%
5	**Training Plan**	909d	07/03/17	12/24/20		42%
6	**DDCAT/DDCMHT Assessment Capacity Development**	335d	09/04/17	12/14/18		100%
7	Deliver DDCAT/DDCMHT Assessor Training	80d	09/04/17	12/22/17		100%
8	Deliver Up To 30 Hours DDCAT/DDCMHT Consulting	335d	09/04/17	12/14/18		100%
9	**Program Leader Development**	147d	09/07/17	03/30/18		100%
10	Schedule Co-Occurring Disorders Program Leader Training	79d	09/07/17	12/26/17		100%
11	Deliver Co-Occurring Disorders Program Leader Training	60d	01/08/18	03/30/18		100%
12	**Primary Care and Support Organization Development**	909d	07/03/17	12/24/20		11%
13	Define 2018 ITCOD Training Program for Primary Care and Support Organizations	126d	07/03/17	12/25/17		100%
14	Define 2019 ITCOD Training Program for Primary Care and Support Organizations	146d	06/04/18	12/24/18		
15	Define 2020 ITCOD Training Program for Primary Care and Support Organizations	148d	06/03/19	12/25/19		
16	Deliver 2018 ITCOD Training for Primary Care and Support Organizations	254d	01/02/18	12/21/18		
17	Deliver 2019 ITCOD Training for Primary Care and Support Organizations	255d	01/02/19	12/24/19		
18	Deliver 2020 ITCOD Training for Primary Care and Support Organizations	256d	01/02/20	12/24/20		
19	**DDCAT/DDCMHT Organizational Assessments**	864d	09/04/17	12/24/20		26%
20	**July - December 2017**	82d	09/04/17	12/26/17		100%
21	Deliver Up to 4 Organizational Assessments with DDC Consultants and N4H Trainees	64d	09/04/17	11/30/17		100%
22	Create Up to 4 Organizational Assessment Reports	40d	10/10/17	12/04/17		100%
23	Deliver Up to 4 Organizational Assessment Report Presentations	20d	11/07/17	12/04/17		100%
24	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	36d	11/07/17	12/26/17		100%
25	**Progress Assessment Checkpoint**	14d	11/03/17	11/22/17		100%
26	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	11/03/17	11/16/17		100%
27	Document feedback and any areas of improvement for future DDC reviews	2d	11/17/17	11/20/17		100%
28	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/21/17	11/22/17		100%
29	Gather Feedback from Assessor Trainees from Dual Diagnosis Capability Review Training and Shadowing	1d	11/03/17	11/03/17		100%
30	Document feedback and incorporate any areas of need for additional training in project schedule	5d	11/06/17	11/10/17		100%
31	**January - June 2018**	128d	01/02/18	06/28/18		100%
32	Deliver Up to 5 New Organizational Assessments (N4H Assessors)	105d	01/02/18	05/28/18		100%
33	Create Up to 5 Organizational Assessment Reports	90d	01/23/18	05/28/18		100%
34	Deliver Up to 5 Organizational Assessment Report Presentations	90d	01/23/18	05/28/18		100%
35	Create Up to 5 Dual Diagnosis Capability Quality Improvement Plans	70d	03/06/18	06/11/18		100%
36	N4H ITCOD Team Approves Funding for up to 5 Organization Dual Diagnosis Capability Quality Improvement Plans	72d	03/21/18	06/28/18		100%
37	**Progress Assessment Checkpoint**	56d	04/02/18	06/18/18		100%
38	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	15d	04/02/18	04/20/18		100%
39	Modify in-progress Quality Improvement Plans (if required)	5d	04/23/18	04/27/18		100%

	Task Name	Duration	Start	Finish	Predecessors	% Complete
40	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	04/30/18	05/04/18		100%
41	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	05/30/18	06/12/18		100%
42	Document feedback and any areas of improvement for future DDC reviews	2d	06/13/18	06/14/18		100%
43	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	06/15/18	06/18/18		100%
44	**July - December 2018**	128d	07/02/18	12/26/18		
45	**New Organization Assessments**	128d	07/02/18	12/26/18		
46	Deliver Up to 3 New Organizational Assessments (N4H Assessors)	109d	07/02/18	11/29/18		
47	Create Up to 3 Organizational Assessment Reports	90d	07/30/18	11/30/18		
48	Deliver Up to 3 Organizational Assessment Report Presentations	90d	07/30/18	11/30/18		
49	Create Up to 3 Dual Diagnosis Capability Quality Improvement Plans	67d	09/11/18	12/12/18		
50	N4H ITCOD Team Approves Funding for up to 7 Organization Dual Diagnosis Capability Quality Improvement Plans	69d	09/21/18	12/26/18		
51	**12 month Organization Re-assessments**	128d	07/02/18	12/26/18		
52	Deliver Up to 2 Organizational Re-assessments (N4H Assessors)	109d	07/02/18	11/29/18		
53	Create Up to 2 Organizational Re-assessment Reports	90d	07/30/18	11/30/18		
54	Deliver Up to 2 Organizational Re-assessment Report Presentations	60d	09/11/18	12/03/18		
55	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plan UPDATES	52d	10/02/18	12/12/18		
56	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plan	50d	10/18/18	12/26/18		
57	**Progress Assessment Checkpoint**	62d	09/03/18	11/27/18		
58	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	09/03/18	09/28/18		
59	Modify in-progress Quality Improvement Plans (if required)	5d	10/01/18	10/05/18		
60	Present to Project Advisory and Steering Committee (if funding changes needed)	1d	10/08/18	10/08/18		
61	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	11/06/18	11/19/18		
62	Document feedback and any areas of improvement for future DDC reviews	2d	11/20/18	11/21/18		
63	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/26/18	11/27/18		
64	**January - December 2019**	255d	01/02/19	12/24/19		
65	**New Organization Assessments**	255d	01/02/19	12/24/19		
66	Deliver Up to 2 New Organizational Assessments (N4H Assessors)	225d	01/02/19	11/12/19		
67	Create Up to 2 Organizational Assessment Reports	190d	03/13/19	12/03/19		
68	Deliver Up to 2 Organizational Assessment Report Presentations	175d	04/03/19	12/03/19		
69	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	165d	04/17/19	12/03/19		
70	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plans	170d	05/01/19	12/24/19		
71	**12 month Organization Re-assessments**	255d	01/02/19	12/24/19		
72	Deliver Up to 12 Organizational Re-assessments (N4H Assessors)	230d	01/02/19	11/19/19		
73	Create Up to 12 Organizational Re-assessment Reports	190d	03/20/19	12/10/19		
74	Deliver Up to 12 Organizational Re-assessment Report Presentations	175d	04/10/19	12/10/19		
75	Create Up to 12 Dual Diagnosis Capability Quality Improvement Plan UPDATES	165d	04/24/19	12/10/19		
76	N4H ITCOD Team Approves Funding for up to 12 Organization Dual Diagnosis Capability QIP Updates	170d	05/01/19	12/24/19		
77	**Progress Assessment Checkpoint**	128d	05/20/19	11/13/19		
78	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	05/20/19	06/14/19		
79	Modify in-progress Quality Improvement Plans (if required)	20d	06/18/19	07/15/19		

	Task Name	Duration	Start	Finish	Predecessors	% Complete
80	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	07/16/19	07/22/19		
81	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	10/25/19	11/07/19		
82	Document feedback and any areas of improvement for future DDC reviews	2d	11/08/19	11/11/19		
83	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/12/19	11/13/19		
84	**January - December 2020**	254d	01/06/20	12/24/20		
85	**New Organization Assessments**	254d	01/06/20	12/24/20		
86	Deliver Up to 2 New Organizational Assessments (N4H Assessors)	225d	01/06/20	11/13/20		
87	Create Up to 2 Organizational Assessment Reports	190d	03/16/20	12/04/20		
88	Deliver Up to 2 Organizational Assessment Report Presentations	175d	04/06/20	12/04/20		
89	Create Up to 2 Dual Diagnosis Capability Quality Improvement Plans	165d	04/20/20	12/04/20		
90	N4H ITCOD Team Approves Funding for up to 2 Organization Dual Diagnosis Capability Quality Improvement Plans	179d	04/20/20	12/24/20		
91	**12 month Organization Re-assessments**	254d	01/06/20	12/24/20		
92	Deliver Up to 14 Organizational Re-assessments (N4H Assessors)	225d	01/06/20	11/13/20		
93	Create Up to 14 Organizational Re-assessment Reports	190d	03/16/20	12/04/20		
94	Deliver Up to 14 Organizational Re-assessment Report Presentations	175d	04/06/20	12/04/20		
95	Create Up to 14 Dual Diagnosis Capability Quality Improvement Plan UPDATES	165d	04/20/20	12/04/20		
96	N4H ITCOD Team Approves Funding for up to 14 Organization Dual Diagnosis Capability QIP Updates	179d	04/20/20	12/24/20		
97	**Progress Assessment Checkpoint**	136d	05/04/20	11/09/20		
98	Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	20d	05/04/20	05/29/20		
99	Modify in-progress Quality Improvement Plans (if required)	20d	06/02/20	06/29/20		
100	Present to Project Advisory and Steering Committee (if funding changes needed)	5d	06/30/20	07/06/20		
101	Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	10/21/20	11/03/20		
102	Document feedback and any areas of improvement for future DDC reviews	2d	11/04/20	11/05/20		
103	Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	11/06/20	11/09/20		
104	**ITCOD Practice Improvement Community Meetings (Bi-Yearly)**	780d	01/01/18	12/25/20		17%
105	Jan - June 2018 ITCOD Practice Improvement Community Meeting	128d	01/01/18	06/27/18		100%
106	July - Dec 2018 ITCOD Practice Improvement Community Meeting	126d	07/02/18	12/24/18		
107	Jan - June 2019 ITCOD Practice Improvement Community Meeting	128d	01/01/19	06/27/19		
108	July - Dec 2019 ITCOD Practice Improvement Community Meeting	128d	07/01/19	12/25/19		
109	Jan - June 2020 ITCOD Practice Improvement Community Meeting	129d	01/01/20	06/29/20		
110	July - Dec 2020 ITCOD Practice Improvement Community Meeting	128d	07/01/20	12/25/20		
111	**ITCOD E-Newsletters (Bi-Yearly)**	865d	09/01/17	12/24/20		28%
112	Create July - December 2017 ITCOD E-Newsletter to Network 4 Health Participants	82d	09/01/17	12/25/17		100%
113	Create Jan - June 2018 ITCOD E-Newsletter to Network 4 Health Participants	85d	03/01/18	06/27/18		100%
114	Create July - December 2018 ITCOD E-Newsletter to Network 4 Health Participants	83d	09/03/18	12/26/18		
115	Create Jan - June 2019 ITCOD E-Newsletter to Network 4 Health Participants	84d	03/04/19	06/27/19		
116	Create July - December 2019 ITCOD E-Newsletter to Network 4 Health Participants	84d	09/02/19	12/26/19		
117	Create Jan - June 2020 ITCOD E-Newsletter to Network 4 Health Participants	85d	03/02/20	06/26/20		
118	Create July - December 2020 ITCOD E-Newsletter to Network 4 Health Participants	83d	09/01/20	12/24/20		
119	**Evaluation Metrics Reporting (Data)**	935d	07/03/17	01/29/21		29%

	Task Name	Duration	Start	Finish	Predecessors	% Complete
120	**July - December 2017**	152d	07/03/17	01/30/18		100%
121	Select data collection tool(s)	64d	07/03/17	09/28/17		100%
122	Implement data collection tool for July - December 2017 Assessment Organizations (post assessment)	62d	10/02/17	12/26/17		100%
123	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	22d	01/01/18	01/30/18		100%
124	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	22d	01/01/18	01/30/18		100%
125	Report # of organizations assessed by DDCAT or DDCMHT index	22d	01/01/18	01/30/18		100%
126	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	22d	01/01/18	01/30/18		100%
127	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	22d	01/01/18	01/30/18		100%
128	**January - June 2018**	128d	02/01/18	07/30/18		45%
129	Implement data collection tool for Jan - June 2018 Assessment Organizations	106d	02/01/18	06/28/18		0%
130	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	21d	07/02/18	07/30/18		0%
131	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	21d	07/02/18	07/30/18		100%
132	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	21d	07/02/18	07/30/18		100%
133	Report # of organizations assessed by DDCAT or CCMHT index	21d	07/02/18	07/30/18		100%
134	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	21d	07/02/18	07/30/18		100%
135	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	21d	07/02/18	07/30/18		100%
136	**July - December 2018**	132d	08/01/18	01/31/19		
137	Implement data collection tool for July - December 2018 Assessment Organizations (post assessment)	105d	08/01/18	12/25/18		
138	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	23d	01/01/19	01/31/19		
139	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	23d	01/01/19	01/31/19		
140	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/19	01/31/19		
141	Report # of organizations assessed by DDCAT or CCMHT index	23d	01/01/19	01/31/19		
142	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	23d	01/01/19	01/31/19		
143	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	23d	01/01/19	01/31/19		
144	**January - December 2019**	23d	01/01/20	01/31/20		
145	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	23d	01/01/20	01/31/20		
146	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	23d	01/01/20	01/31/20		
147	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/20	01/31/20		
148	Report # of organizations assessed by DDCAT or CCMHT index	23d	01/01/20	01/31/20		
149	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	23d	01/01/20	01/31/20		
150	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	23d	01/01/20	01/31/20		
151	**January - December 2020**	283d	01/01/20	01/29/21		
152	Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	21d	01/01/21	01/29/21		
153	Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	21d	01/01/21	01/29/21		
154	Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	23d	01/01/20	01/31/20		
155	Report # of organizations assessed by DDCAT or CCMHT index	21d	01/01/21	01/29/21		
156	Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	21d	01/01/21	01/29/21		
157	Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	21d	01/01/21	01/29/21		
158	**Process Milestones by Reporting Period**	914d	06/30/17	12/31/20		20%
159	**Period ending June 30, 2017**	0	06/30/17	06/30/17		100%

	Task Name	Duration	Start	Finish	Predecessors	% Complete
160	Develop Implementation Plan	0	06/30/17	06/30/17		100%
161	Create Implementation Schedule/Timeline	0	06/30/17	06/30/17		100%
162	Create Budget	0	06/30/17	06/30/17		100%
163	Create Workforce Plan	0	06/30/17	06/30/17		100%
164	Create Training Plan	0	06/30/17	06/30/17		100%
165	Vendor Selection for Dual Diagnosis Capability Assessments	0	06/30/17	06/30/17		100%
166	Participant Selection through 12/31/17	0	06/30/17	06/30/17		100%
167	Organizational Leadership Sign-off	0	06/30/17	06/30/17		100%
168	**July - December 2017**	85d	09/01/17	12/29/17		100%
169	Recruit N4H DDCAT/DDCMHT Assessors (Workforce Plan)	0	09/01/17	09/01/17		100%
170	Complete Schedule for July - December 2017 Dual Diagnosis Capability Organizational Assessments	0	09/15/17	09/15/17		100%
171	Complete up to 4 Dual Diagnosis Capability Organizational Assessments	0	12/04/17	12/04/17		100%
172	Deliver DDCAT/DDCMHT Assessor Training (Training Plan)	0	12/27/17	12/27/17		100%
173	Recruit N4H Co-Occurring Disorders Clinical Director (Workforce Plan)	0	12/29/17	12/29/17		100%
174	Schedule Co-occurring Disorders Program Leaders Training (Training Plan)	0	12/29/17	12/29/17		100%
175	Complete up to 1 Dual Diagnosis Capability Quality Improvement Plan	0	12/29/17	12/29/17		100%
176	Define 2018 ITCOD Training Program for Primary Care and Support Organizations	0	12/29/17	12/29/17		100%
177	Deliver ITCOD e-Newsletter	0	12/29/17	12/29/17		100%
178	**January - June 2018**	73d	03/19/18	06/28/18		100%
179	Complete Schedule for January - June 2018 Dual Diagnosis Capability Organizational Assessments	0	03/19/18	03/19/18		100%
180	Deliver Co-Occurring Disorders Program Leader Training	0	03/30/18	03/30/18		100%
181	Complete up to 5 Dual Diagnosis Capability Organizational Assessments	0	05/29/18	05/29/18		100%
182	Complete up to 5 Dual Diagnosis Capability Quality Improvement Plans	0	06/12/18	06/12/18		100%
183	Complete Jan - June 2018 ITCOD Practice Improvement Community Meeting	0	06/28/18	06/28/18		100%
184	Deliver ITCOD e-Newsletter	0	06/28/18	06/28/18		100%
185	**July - December 2018**	346d	09/01/17	12/31/18		
186	Complete Schedule for Jul - Dec 2018 Dual Diagnosis Capability Organizational Assessments	0	09/01/17	09/01/17		
187	Complete up to 3 Dual Diagnosis Capability Organizational Assessments	0	12/05/18	12/05/18		
188	Complete up to 2 Dual Diagnosis Capability Organizational Re-assessments	0	12/05/18	12/05/18		
189	Complete up to 7 Quality Improvement Plans	0	12/14/18	12/14/18		
190	Complete up to 2 Dual Diagnosis Capability QIP UPDATES	0	12/14/18	12/14/18		
191	Deliver 2018 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/18	12/31/18		
192	Define 2019 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/18	12/31/18		
193	Complete July - Dec 2018 ITCOD Practice Improvement Community Meeting	0	12/31/18	12/31/18		
194	Deliver ITCOD e-Newsletter	0	12/31/18	12/31/18		
195	**January - December 2019**	151d	06/03/19	12/31/19		
196	Deliver 2019 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/19	12/31/19		
197	Define 2020 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/19	12/31/19		
198	Jan-Dec 2019 Dual Diagnosis Capability Organizational Assessments SCHEDULED	0	06/03/19	06/03/19		
199	Complete up to 2 NEW Dual Diagnosis Capability Organizational Assessments	0	12/09/19	12/09/19		

Attachment_E4.1b

	Task Name	Duration	Start	Finish	Predecessors	% Complete
200	Complete up to 2 NEW Quality Improvement Plans	0	12/09/19	12/09/19		
201	Complete up to 12 Dual Diagnosis Capability Organizational Re-assessments	0	12/16/19	12/16/19		
202	Complete up to 12 Dual Diagnosis Capability QIP UPDATES	0	12/16/19	12/16/19		
203	Complete Jan - June 2019 ITCOD Practice Improvement Community Meeting	0	06/28/19	06/28/19		
204	Complete July - Dec 2019 ITCOD Practice Improvement Community Meeting	0	12/31/19	12/31/19		
205	Deliver ITCOD e-Newsletter (Jan - Jun 2019)	0	06/28/19	06/28/19		
206	Deliver ITCOD e-Newsletter (July - Dec 2019)	0	12/31/19	12/31/19		
207	**January - December 2020**	153d	06/01/20	12/31/20		
208	Complete Schedule for Jan-Dec 2020 Dual Diagnosis Capability Organizational Assessments	0	06/01/20	06/01/20		
209	Deliver ITCOD e-Newsletter (Jan - Jun 2020)	0	06/29/20	06/29/20		
210	Complete Jan - June 2020 ITCOD Practice Improvement Community Meeting	0	06/30/20	06/30/20		
211	Complete up to 2 NEW Dual Diagnosis Capability Organizational Assessments	0	12/10/20	12/10/20		
212	Complete up to 2 NEW Quality Improvement Plans	0	12/10/20	12/10/20		
213	Complete up to 14 Dual Diagnosis Capability Organizational Re-assessments	0	12/10/20	12/10/20		
214	Complete up to 14 Dual Diagnosis Capability QIP UPDATES	0	12/10/20	12/10/20		
215	Deliver ITCOD e-Newsletter (July - Dec 2020)	0	12/30/20	12/30/20		
216	Complete July - Dec 2020 ITCOD Practice Improvement Community Meeting	0	12/31/20	12/31/20		
217	Deliver 2020 ITCOD Training Program for Primary Care and Support Organizations	0	12/31/20	12/31/20		

Network4Health Training Attendance
E4 Completed Trainings January - June 2018

Course Name	Date(s)	First Name	Last Name	Organization	Role	IDN
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Center for Life Management	VP Clinical Services	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Center for Life Management	Continuum of Care Facilitator	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Center for Life Management	Clinical Supervisor	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	UNH - IDN 4 sub-contractor	NH Citizens Health Initiative	n/a
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Inpatient Director	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Mental Health Center of Greater Manchester	CSP Division Director	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Center for Life Management	Adult Program Development Coordinator	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	IDN 6	Community Navigator	6
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	UNH - IDN 4 sub-contractor	NH Citizens Health Initiative	n/a
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Center for Life Management	Director Clinical Services	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Easterseals NH	Director Clinical Services	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Greater Nashua Mental Health Center	IDDT coordinator	3
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Families in Transition	Program Manager	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Network4Health	Counselor	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Case Manager	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Pastoral Counseling Services	Counselor	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Phoenix House	Program Manager	1
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Phoenix House	Assistant Director	1
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Manchester Community Health Center	Director Behavioral Health Services	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Greater Nashua Mental Health Center	Director Adult Services	3
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Southern NH Health Services, IDN 3	Integration Program Manager	3
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Director of MCT	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Greater Nashua Mental Health Center	unknown	3
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Genesis Behavioral Health	Adult Services Director	5
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Pastoral Counseling Services	Counselor	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Director Emergency Services	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Center for Life Management	Director Access to Care/ Director Adult Clinical Services	4

Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Coordinator, Mobile Crisis Unit	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Co-Occurring Disorders Clinical Director, Network4Health	4
Integrated Treatement of Co-occurring Disorders Program Leader Training	1/30/18-1/31/18 (2 days)	[redacted]	[redacted]	Community Partners NH	ACT Manager	6
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Granite pathways	Case manager	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Catholic Medical Center	Clinical Coordinator, Primary Care	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Catholic Medical Center	CMA	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Willowbend Family Practice	RN, Primary Care	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Catholic Medical Center	Office Coordinator	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Catholic Medical Center	RN, Primary Care	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Catholic Medical Center	Practice Manager, Primary Care	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Catholic Medical Center - Bedford	RN Care Coordinator, Primary Care	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	Catholic Medical Center - Willowbend Family Practice	RN Care Coordinator, Primary Care	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	International Institute of New England	Case Specialist	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	International Institute of New England	Health Worker	4
Mental Health First Aid	4/11/18-4/12/18 (two days)	[redacted]	[redacted]	International Institute of New England	Program Director	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Sergeant	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Sergeant	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Sergeant	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Sergeant	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Sergeant	4
Mental Health First Aid	5/1/18-5/2/18 (two days)	[redacted]	[redacted]	Hillborough County Department of Corrections	Field Training Officer	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Health Dept	Public Health Specialist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	NAMI NH	Family Support	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	International Institute of New England	Community Health Worker	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Upper Room	Program Facilitator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center	CHW	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	International Institute of New England	Case Specialist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	MCRT Clinician	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center- Child Health Servic	CHW	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Home Visitor	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Granite Pathways	Case Manager, crsw	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Program Coordinator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center	Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Family Support Worker	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Upper Room	Program Coordinator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Parent Plus Home Support	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Granite Pathways	Mental Health Generalist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Family Support Worker	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Catholic Medical Center- Behavioral Health	LICSW	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Crotched Mountain	Care Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Program Director	4

Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	ISO/IHB Family Therapist/Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center	CHW/BHC	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center	Community Health Worker	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	The Moore Center	Clinical Direct Support Staff	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Easterseals	Care Coordinator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Network4Health/MHCGM	Director	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	International Institute of New England	Health Worker	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center- Child Health Servic	Child Health Worker	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Cotched Mountain	RN Team Lead	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Center for Life Management	ACT team peer specialist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center	Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	MFT/ Clinical Intern	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Elliot Hospital	Registered Nurse	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	The Moore Center	Program Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Center for Life Management	Adult Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Home Visitor Training and Development Coordinator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Catholic Medical Center	Clinician	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Clinical Supervisor	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Center for Life Management	Adult ACT Clinician	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Home Visitor	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Famly Therapist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Life Coping, Inc.	Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Street Outreach Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Manchester Community Health Center- Child Health Servic	Project LAUNCH Care Coordinator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Makin It Happen	Program Coordinator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Director ,ITCOD	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Upper Room	Therapist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Life Coping Inc.	CFI Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Enhanced Care Coordinator	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Elliot Hospital	Psychiatric Nurse	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Home Health and Hospice Care	Medical Social Worker	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Granite Pathways	Director of Mental Health Services	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Clinician/IHB-ISO Case Manager	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Mental Health Center of Greater Manchester	Care Transitions Coach	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Child and Family Services	Clinician	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Granite pathways	Recovery Specialist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Center for Life Management	ACT Outreach Specialist	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	N4H/MHCGM	Transition Coach	4
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	UW of Greater Nashua	President	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Greater Nashua Mental Health	APRN	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Greater Nashua Mental Health	IDDT Therapist	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	The Front Door Agency	Housing Advocate	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Revive Recovery	Director	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	The Salvation Army	Director of Social Services	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Harbor Homes	Mobile Crisis	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Revive Recovery Center	Peer Recovery Support manager	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Greater Nashua Mental Health	Supported Employment Specialist	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Merrimack River Med Services	Treatment Center Director	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	NAMI Nashua	Volunteer	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Emmaus Institute	Executive director	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Greater Nashua Mental Health		3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Greater Nashua Mental Health	IDDT Case Manager	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Lamprey Health Care	Care Coordinator	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Emmaus Institute	Strategic Marketing	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	St. Josephs	Not reported	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Emmaus Institute	Staff supervisor	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Greater Nashua Mental Health	Case Manager	3
Initial Training on Addiction	5/10/2018	[redacted]	[redacted]	Greater Nashua Mental Health	Coordinator/ therapist	3

IHI Virtual Expedition: Taking on the Opioid Crisis Webinar Series	2/28/18, 3/14/18, 3/28/18, 4/11/18, 4/18/18	[redacted]	[redacted]	Dartmouth-Hitchcock Primary Care	Physician	4
IHI Virtual Expedition: Taking on the Opioid Crisis Webinar Series	2/28/18, 3/14/18, 3/28/18, 4/11/18, 4/18/18	[redacted]	[redacted]	Dartmouth-Hitchcock Primary Care	Physician	4
IHI Virtual Expedition: Taking on the Opioid Crisis Webinar Series	2/28/18, 3/14/18, 3/28/18, 4/11/18, 4/18/18	[redacted]	[redacted]	Dartmouth-Hitchcock Primary Care	Physician	4
IHI Virtual Expedition: Taking on the Opioid Crisis Webinar Series	2/28/18, 3/14/18, 3/28/18, 4/11/18, 4/18/18	[redacted]	[redacted]	Dartmouth-Hitchcock Primary Care	Physician	4
IHI Virtual Expedition: Taking on the Opioid Crisis Webinar Series	2/28/18, 3/14/18, 3/28/18, 4/11/18, 4/18/18	[redacted]	[redacted]	Catholic Medical Center	CMA & Office Coordinator	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Program Aide	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Housing Advocate	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Housing Advocate	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Case Manager NHNH	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Case Manager NHNH	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Program Manager Angie's House	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Recovery Care Lin's Place	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Support Services	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Open Doors	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Willows Substance Use Treatment Center	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	VP Clinical and Supportive Services	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	CRSW	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Shelter Manager	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Intake for MHCGM	4
Overcoming Stigma: Strategies for Healthcare Professionals	6/28/2018	[redacted]	[redacted]	Families in Transition - New Horizons (Quality Improvement Plan Training)	Mobile Crisis Response Team	4

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

Provide a brief narrative describing the current use of APMs among partners.

As noted in our last submission, there is some activity by Network4Health partners. For example, region's two community mental health centers are participating in population-based capitation payments within the Medicaid managed care program. This arrangement includes a minimum maintenance of effort threshold that assures a level of service delivery. Quality metrics exist. In addition, the Dartmouth Hitchcock Clinics in Manchester and Bedford participate in alternative payment models utilized by the NH Dartmouth Hitchcock system.

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.

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	As of 6/30/18	As of 12/31/18
Participate in development of statewide APM roadmap through workgroups and stakeholder meetings	Yes	Yes	
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures		In progress	
Develop the financial, clinical and legal infrastructure required to support APMs		In progress	

Statewide APM Taskforce and Implementation Plan Activity	Progress		
	As of 12/31/17	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	

Network4Health is committed to working collaboratively with NH DHHS, NH Medicaid Care Management organizations and others in the development and implementation of the NH DSRIP Alternative Payment Models Roadmap. A Roadmap was released and developed with participation from the seven regional integrated delivery networks. Network4Health has been informed by NH DHHS staff that the state plan has been approved by the Centers for Medicare and Medicaid Services.

The NH Office of Medicaid Services, with partners from the UNH School of Law and the NH Institute for Health Policy and Practice, convened a Statewide APM Stakeholder workgroup. The Network4Health Executive Director represented the Region 4 Integrated Delivery Network. Representatives from hospital systems, federally qualified health centers, community mental health centers and others participated. Four meetings of the workgroup were held with the final meeting occurring in March 2018. The final report summarized participant feedback and was released in April.

The Network4Health APM IDN Implementation Plan is under development and on track to be completed by December 2018. It will include education, readiness and monitoring of partners who are participating in any other alternative payment arrangements. We will work closely with DHHS and the selected Medicaid Care Management organizations to assure provider preparedness. Currently, during the development of our Integrated Health Care organizational Integration Enhancement Plans, discussion of this element of the Transformation Waiver have occurred especially as it relates to sustainability. During Network4Health's planned September All Partners Meeting, we plan to present on alternative payment models and value based purchasing. Several Network4Health staff members and network partners (currently 8 individuals) plan to attend the 3rd Annual Value-Based Care Summit scheduled to be held in Boston October 17 to 19, 2018. The agenda includes such topics as bundled payments, supply chain management, leveraging technology, telehealth, information sharing and quality metrics, lessons learned from care coordination among others. As this process moves forward, Network4Health anticipates that consultants may be necessary to provide technical support to Network4Health and its partners in efforts to implement any planned alternative payment models. The Network4Health APM implementation plan is subject to the approval of the Steering Committee.

The recently released draft RFP documents for the upcoming Medicaid Care Management Services re-procurement includes indicate that the "MCOs are required to develop a strategy for moving fifty percent (50%) of their medical expenditures into qualifying APM's". Also, "MCOs must provide to DHHS and Providers the methodology they will employ, including with respect to Member attribution, any attachment points, quality performance targets and risk adjustment methodology". The draft contract directly connects the MCO APM requirement to the NH Building Capacity for Transformation Waiver. Network4Health participated in the July public hearings to support the involvement of IDNs in this work.