

New Hampshire
Department of Health and Human Services

Building Capacity for Transformation Waiver

Integrated Delivery Network

Semi-Annual Report

(July – December 2017)

Network4Health (IDN 4)

April 5, 2018



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Project Plan Implementation Narrative

Network4Health is 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 service providers who address the social determinates of health.

Network4Health has continued to make significant progress during the period from July 1, 2017 – December 31, 2017. During the reporting period, N4H has made exciting first steps in operationalizing the project plans for our Integrated Delivery Network. A key priority for this reporting period has been the recruitment of staff to put the project plans into action. During this effort, Network4Health has experienced the very same challenges experienced by our network partners when attempting to fill open positions. Our first hire, the Director for Integrated Treatment Disorders (E4), began full time employment at the beginning of September. In October, the N4H Workforce Development Director (A1) joined the team as did the Network4Health Director of HIT (A2). The Director of the planned Partial Hospital Program (D3) was hired in November and our Director of Care Transitions (C1) began part time in December moving to full time on January 2, 2018. Rounding out the leadership team, our Director of Integrated Healthcare (B1) began employment on January 2, 2018 as well. Four Transitions Coaches have been hired as well as the Care Transitions administrative assistant. Other positions yet to be filled include two additional Transition Coaches and an administrative assistant for the Workforce Development project.

Soliciting Community Input

Network4Health continues to believe its success requires a strong relationship with the communities we serve and our leadership is keenly aware of the need to both be involved in the community and solicit their input. Since our formation, we have made a concerted effort to reach out to community groups and organizations.

Network4Health formulated a plan to create both a Patient/Client Advisory Council as well as a Stakeholders Advisory Counsel. The plan was first presented to the Steering Committee at the August meeting and was approved at the September meeting. Nominations for membership were solicited from Network4Health partners. However, only three nominations combined were received. In discussing with network partners, several challenges and barriers were identified to the proposed advisory councils including: unavailability of volunteers, reluctance to join an advisory board for an unfamiliar organization, and transportation demands despite a plan to host meetings throughout the region. Given the lack of interest in our initial approach, the plan was revisited and an alternative was developed that could still obtain the intended objective of community input. The revised plan was approved by the Steering Committee at the October meeting. Under this plan, Network4Health is partnering with Making It Happen (Greater Manchester Regional Public Health Network- Continuum of Care) to leverage existing community group meetings to elicit community input and engagement. A meeting has been held on December 11, 2017 with the South Central Regional Public Health Network Continuum of Care

Coordinator to establish outreach with community organizations in the communities they serve. We are formulating and piloting a set of standardized discussion questions during these community meetings. We have leveraged help from the NH Center of Excellence which has contracted through the NH DHHS Bureau of Drug and Alcohol Services to provide technical assistance to the Continuum of Care coordinators of to the 13 regional public health networks. Our plan is to hold up to 6 community engagement meetings throughout the region in each of the upcoming reporting periods.

During this reporting period, Network4Health has had several interactions across the region.

- During the current reporting period, Network4Health has held four community meetings including with:
 - the Rockingham County Sheriff’s Association (approximately 15 participants),
 - the Catholic Medical Center Patient Family Advisory Committee (8 participants),
 - the NAMI Manchester Affiliate (10 participants), and
 - the Manchester Police Department Citizen’s Advisory Board (25 participants).

When asked about any examples of progress in improving care, participants noted:

- Improved insurance availability;
- increased use of telehealth;
- availability of patient portals and on line scheduling;
- increased role of peer support and recovery coaching; and,
- availability of family support.

When asked about gaps, barriers and challenges, participants identified:

- timely access to care especially behavioral health care;
- timely access to prescriber services and medication monitoring to assure adherence; extended intake process from referral to care;
- staff turnover and workforce shortages;
- continuing erosion of resources;
- lack of reliable transportation support;
- insufficient stock of housing resources;
- high insurance copays and deductibles;
- privacy rules that impede inclusion of support system;
- ineffective use of medical interpreters by care providers; and,
- a lack of a team approach to care.
- Network4Health’s Executive Director has also had meetings during this reporting period with The Race, Ethnicity & Language Committee of the NH Health Equity Partnership, and the NH Legislative Interoperability Committee. He also serves as a member of the Hillsborough County Coalition for Mental Health & Justice.
- Network4Health launched its website- www.network4health-nh.org –in December. Links to network partners, NH DHHS, and the NH Learning Collaborative are included. Network4Health

is currently working on adding Google translator for individuals who do not have English as a primary language.

- Network4Health has also created a YouTube Channel that has been used for communicating information about the Integrated Treatment of Co-Occurring Disorders project. Further development is required before making the channel public.

Network Development

Network4Health participating partner organizations did not change during this reporting period. Network4Health continues to monitor activities within the region and gives consideration to existing partner participation and shall continue to add new partners as needs arise that will benefit the residents in Region IV. On December 20, 2017, it was announced that Serenity Place, a key Network4Health partner, was placed in receivership. The named receiver is Families In Transition, which is also a Network4Health partner. The Steering Committee has discussed this situation and is monitoring the implications. It has the greatest impact in our D3 project where Serenity Place and the Elliot Health System were working collaboratively to develop a partial hospitalization program.

Network4Health held its quarterly all network partner meetings on September 14, 2017 and December 14, 2017. These meetings allow an opportunity to provide Network4Health progress updates. The September meeting provided a focused presentation on the social determinants of health by the Network4Health Learning Collaborative Innovation Agent and three Network4Health partner representatives. The December meeting included a presentation of the new Network4Health website. Also, all Project Directors and assigned project managers provided detailed implementation status reports.

Addressing the Opioid Crisis

Network4Health continues to focus on how it and its partners can make a difference in the opioid crisis through the projects we have chosen to implement as well as the following activities:

- Participation on a monthly basis in meetings of the Regional Public Health Network, Continuum of Care, [REDACTED], of Network4Health partner organization Makin It Happen. Attendees include the Network4Health Executive Director as well as representatives of network partner organizations.
- Network4Health is a cosponsor of the Empower You Learning Series organized by Makin It Happen. This education series is designed to provide information about the addiction epidemic to the general public. Two sessions were held during the reporting period.
- Network4Health's lead organization, Catholic Medical Center, sponsored the CMC 3rd Annual Summit on Treatment of Opioid-Dependent Patients and Pain held on November 17, 2017. Multiple Network4Health partner organizations were among the summit participants.
- Network4Health's Executive Director and our partners are involved in a community planning effort to address the needs of clients impacted by the placement of Serenity Place into receivership.

- Network4Health’s Executive Director has been appointed to the recently announced Mayor’s Opioid Advisory Council in Manchester.

Governance

Network4Health maintains a Steering Committee of 12 members to provide governance to the network. The Steering Committee continues to meet monthly and provides oversight of project plan development, implementation and budgeting. Membership has remained relatively stable. Two changes in membership have occurred during the reporting period. As approved by the Steering Committee [REDACTED], Elliot Health System Vice President of Strategy and Government Relations, replaced [REDACTED] in November and [REDACTED] Granite United Way Vice President of Public Health Services and Prevention replaced [REDACTED]

Monitoring Progress

Network4Health will continue to monitor our progress on meeting our and the Department’s goals on a 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, Network4Health changed its community engagement plan to ensure appropriate feedback. Instead of having separate patient/family and stakeholder advisory councils, we are leveraging existing community groups to engage and obtain input. In terms of Network Development, Network4Health will monitor its membership on a regular basis and quarterly will report on the potential for new members to join Network4Health. To retain our current membership and keep them engaged throughout the project, Network4Health continues to hold a quarterly partnership meeting. The Steering Committee meets on a monthly basis and is actively involved in the daily activities of Network4Health.

Network4Health continues to be engaged in efforts to combat the opiate crisis in New Hampshire. As part of this effort, Network4Health will be represented monthly at the Continuum of Care Meetings, and will continue to participate in, and sponsor where appropriate, community events and forums to address the opioid crisis.

Implementation Activity/ Milestone:	Responsible Party/ Organization	Timeline	Progress Measure / Notes
Community Input			
In partnership with the Greater Manchester and South Central Regional Public Health Network Continuum of Care Coordinators, Network4Health will participate in existing community/organizational meetings to elicit community input and engagement.	N4H Executive Director	Attend six outreach meetings over six month period	Approach modified to ensure appropriate community input. First meeting held in December 2017.
Implementation Activity/Milestone:	Responsible Party/ Organization	Timeline	Progress Measure
Network Development			
Continue to consider whether any new partners should be invited to join Network4Health	N4H Executive Director	Quarterly	Quarterly review of partners and

			potential for new members. No new members added.
Hold quarterly all partner meetings	N4H Executive Director	Quarterly	Quarterly all partner meetings held in September and December.
Implementation Activity/Milestone: Addressing the Opioid Crisis	Responsible Party/Organization	Timeline	Progress Measure
Participate in ongoing community activities and presentations focused on the Opioid crisis.	N4H Executive Director; N4H partner organizations	Quarterly	Network4Health was actively involved in several activities during the reporting period.
Participate in monthly Continuum of Care Meetings.	N4H Executive Director; N4H partner organizations	Monthly	Network4Health was represented at each monthly meeting by one or more representatives.
Implementation Activity/Milestone: Governance	Responsible Party/Organization	Timeline	Progress Measure
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. These funds support the salary and benefits of the Executive Director, a Financial Manager (1 FTE) (increased from initial projection of .5 FTE), and Project Management (1.6 FTE). The Population Health Data Analyst (1.0 FTE) served for part of the reporting period before leaving and will not be replaced given the decision to hire a statewide data aggregator. These funds also support three project directors- Care Transitions Director/Clinical Supervisor; SUD Intensive Out Patient Program Director and Director of Integrated Treatment of Co-Occurring Disorders.

Project plan funding has been developed with an emphasis on limited administrative overhead and maximum funding directed to impacting patient care. However, there are remaining administrative expenses to be planned, budgeted and approved by the Steering Committee. These include but are not limited to: administrative support for Executive Director, 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 plans to utilize its Project Design and Capacity Building Funds over the course of the demonstration. The majority of funding is focused on employees and general consulting, and miscellaneous administrative and other costs

expenses not utilized in CY2016 and 2017 will be incurred in years 2018-2020. Budget adjustments for 2018-2020 include: Increase in finance position from half time to full time; discontinuation of data analyst position to do contracting with data aggregator; and, an increase in projected administrative support.

On January 5, 2018, the DHHS Commissioner met with the statewide Integrated Delivery Network leadership to discuss NH 1115 Transformation Waiver funding issues. Negotiations between NH officials and federal officials are ongoing in relation to the calculation of funding for the waiver. The Commissioner expressed cautious optimism that this would be resolved. If funding is reduced significantly, all N4H project budgets will require revisions.

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. Using Microsoft Project or similar platform update your project timeline.

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

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

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

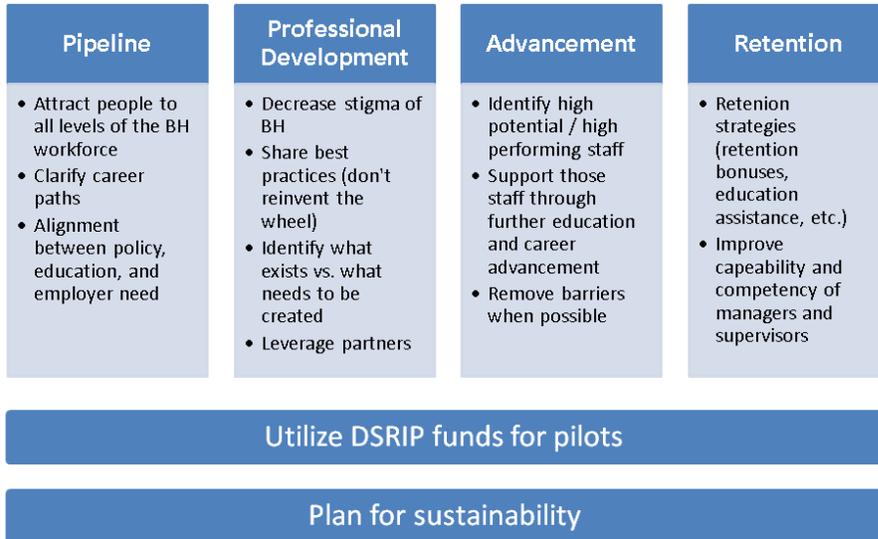
Overview

During this reporting period, Network4Health has taken significant steps in implementing its project plan for developing workforce capacity. Key to this effort is having a Director of Workforce Development. Network4Health hired [REDACTED] for this role and he began in October 2017. [REDACTED] brings a wealth of experience in workforce development, including experience directing workforce development for a large Boston academic medical center.

Between October and December 2017, the director spent his time orienting to new position, orienting to city and partners, orienting to BH landscape. This included activities such as:

- *Met with partners and assessed their workforce needs and roles in the community including Easter Seals, Crotched Mountain, Goodwill, Makin' It Happen NH, Elliot Hospital, NAMI NH, etc.*
- *Created and modified, based on discussions with area colleges, a career lattice tool showing 15 different BH occupations, a description of the role, licensure requirement, supervision requirements, and regional educational programs*
- *Joining the NH Healthcare Sector Partnership meeting as a representative from BH careers*
- *Created workforce development framework for rolling out projects:*

BUILDING THE BEHAVIORAL HEALTH WORKFORCE MODEL



All of this work was important in order to create tools for understanding the landscape of the jobs that are encompassed within BH. In addition, he expanded the membership of the Network4Health Workforce Committee to include representatives from education. He also met with representatives from the state's public workforce system, including the Community College System of NH, NH Vocational Rehab, NH Works, and the NH Office of Workforce Opportunity, to explain the IDN operations and look for areas of collaboration.

Network4Health also continues to be an active participant on the statewide Behavioral Health Workforce Taskforce. Our partnership did suffer a loss with the receivership of Serenity Place. While Families In Transition – another Network4Health partner – has stepped in to serve their patients, the receivership has created some instability within the region that Network4Health is working actively with its partners to solve.

Network4Health's framework for workforce development includes initiatives to increase the pipeline of potential candidates by attracting individuals across all levels to careers in behavioral health, promoting professional development, advancement and retention. Network4Health has made progress on putting in place strategies to improve identified workforce gaps by focusing on education, training, recruitment and retention.

Education

During this reporting period, Network4Health has made significant progress in developing relationships and partnerships with the education system. For example, Network4Health partnered with Southern NH AHEC to coordinate four events in 2018 called the Behavioral Health Education Roundtable. The objective of the roundtables is to create a forum for bringing many of the colleges and universities who have BH programs across the state together to discuss common challenges, look at alignment of systems, create synergies and partnerships. In addition, as noted above, the Director of Workforce developed a career lattice and then shared it with area colleges. Based on their feedback and additional research with the career lattice, Network4Health created career ladder map tools showing education and career progression for areas of BH, SUD treatment, BH nursing and human services, which was shared with area colleges and other organizations to use as an advising tool to help students make decisions about careers in BH.

In addition, Network4Health created a plan for addressing gaps in education in 2018 which includes:

- investigating partnership with one or more colleges in developing a scholarship program for employees of partners to utilize toward education in BH-oriented degree programs;*
- investigating partnership with online tool like Gradifi.com to give money to partner employees that will go directly towards paying down student loans thus effecting retention;*
- creating a partnership with a local college to offer management training to front-line managers as a way to increase their management skills therefore increasing retention;*
- partnering with the Community College System of NH to demonstrate models of apprenticeship and drum up interest among partners to create apprenticeships for BH-oriented positions;*
- partnering with UNH to promote internship opportunities for their HRSA-funded MSW program; partnering with UNH to offer materials and workshops on utilizing Occupational Therapists as a BH care enhancer in integrated PC settings; and,*
- partnering with Westfield State University to offer materials and workshops on utilizing Physician Assistants as a BH care enhancer in integrated PC settings.*

Network4Health has invited two new educational partners to regional workforce taskforce meetings – Manchester Community College and the University of New Hampshire, Manchester. Our intention in doing this is to make sure that the education community understands employer needs in order to keep their educational programs up to date. In addition, Network4Health has also begun developing relationships with Granite State University, Southern New Hampshire University (SNHU), College for America at SNHU and Rivier University. Network4Health has also created visual charts showing career and educational pathways for a variety of jobs focused on mental health and substance use treatment. In addition, Network4Health created a chart that shows the educational pathways a student could take between Manchester Community College and UNH and which programs articulate between the two schools, thus leading to easy transfer of credit. Finally, *as noted above*, Network4Health partnered with the Southern NH Area Health Education Center (AHEC) in planning and delivering a series of roundtable discussions of all colleges and universities in New Hampshire that offer programs in behavioral health.

Training

Through this project, Network4Health supported trainings for both the C1 (Critical Time Intervention) and E4 projects (Integrated Treatment for Co-Occurring Disorders). In addition, Network4Health has sponsored region-wide trainings, including the NH Behavioral Health and Public Policy Summit (held November 6-7, 2017) and the Bi State Recruitment and Retention Conference (held December 5, 2017).

We expect the number of sponsored trainings to increase significantly within the next reporting period now that our Director of Workforce Development is in place.

Recruitment

In terms of recruiting, Network4Health has recruited for and hired 15 positions across Network4Health projects over this reporting period, and continue to actively recruit for additional positions, including an administrative assistant for Workforce Development and two additional CTI coaches. During the next six-month reporting period, Network4Health will re-assess hiring needs for innovation consultants and community health workers as part of the behavioral health integration project (B1) based on project needs. Network4Health has stopped recruiting for positions associated with the Partial Hospitalization Program as we course correct given the receivership of Serenity Place. In addition to focusing on the specific positions needed for the DSRIP projects, Network4Health has also created a behavioral health Career Lattice documenting 15 behavioral health positions, educational requirements, licensing requirements and regional educational programs as well as a behavioral health Nurse Career Lattice which documents 5 nursing positions and their roles in behavioral health, education and licensing requirements and regional educational programs. Network4Health has also created a tool for its partners to use within their own organizations to show career paths.

Network4Health has again conducted a gap analysis assessment by surveying partners to identify gaps and workforce shortages. Our response rate has dropped in this second survey (from 75% to 67%). Based on our first survey we had seen biggest gaps in LADC, MLADC and LICSW positions – we continue to see 19 open positions across those areas (down from 28 in initial survey) from respondents.

Retention

Network4Health has also begun to implement retention strategies. With partner organization Mental Health Center for Greater Manchester (MHCGM), Network4Health has begun to plan an offering for Mental Health First Aid to the region. In addition, Network4Health has partnered with the public workforce system, including Manchester’s One Stop Career Center, NH Works and the Office for Unemployment in order to begin to do industry briefings on behavioral health jobs. Network4Health staff also actively participates 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.

Our updated project plan is included as Attachment_A1.3.

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

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

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

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Decrease the 28 open positions for LICSW, LADC and MLADC identified in the 2017 gap analysis	Add up to 14 staff	19		

While there were only five trainings conducted during this reporting period, Network4Health made progress towards this goal. As noted above, the Director of Workforce began in October 2017. Network4Health spent significant time collecting data on types of trainings across the region and state. Next, Network4Health set up a system to track and identify area employees who were interested in attending trainings and sign up to have them paid for. To expedite this process, Network4Health has designed specific guidelines outlining the steps needed for registering for sponsored trainings, what costs will be covered, responsibilities of participating parties, etc. Network4Health also outlined a slightly different process and guideline for partner employees interested in attending multi-day events we will be sponsoring seats at. This includes language indicating how the employee needs to get manager sign-off for attending, and that Network4Health will be covering costs associated with just registration and not travel, accommodations, food, etc. To manage the process of identifying partner employees interested in training for whom we would be paying for, Network4Health also set up a computerized system in Eventbrite to track partners' employees who are interested in participating in trainings. This free system allows partner employees to indicate which training they are interested in attending and register with us by providing N4H with basic contact info. This system allows us to keep accurate count of who we will be sponsoring, who attended which training, and how much we will be paying the training vendor.

During this time period, Network4Health developed the following plan for training in 2018:

- Roll out off-set productivity process by 2nd quarter 2018
- Continued expansion of training offerings to include national conferences
- On-track to offer over 60 training and conferences through July of 2018

In addition, Network4Health developed a plan to create a workforce newsletter as a primary tool for sharing upcoming training opportunities, as well as other workforce news of note happening in region and articles for managers (as a way to get at increasing employee engagement therefore increasing retention).

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	Up to 1	Up to 2
Integrated Healthcare Clinical Director	Up to 1	0	1	Up to 1	Up to 1
Innovation Consultant	Up to 2	0	0	Up to 2	Up to 2
Community Health Workers	Up to 10	0	0	Up to 10	Up to 10
Co-Occurring Disorders Clinical Director	Up to 1	0	1	Up to 1	Up to 1
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	4 per diem	Up to 4 x .2 FTE	Up to 4 x .2 FTE
Program Coordinator*	Up to 1	0	1	Up to 1	Up to 1
Mental Health Clinician	Up to 1	0	0	Up to 1	Up to 1
Substance Use Disorder Clinician	Up to 1	0	0	Up to 1	Up to 1
Clinical Case Manager, BSW, LMA, RN	Up to 1	0	0	Up to 1	Up to 1
Peer Support Specialist	Up to 1	0	0	UP to 1	UP to 1
Nurse	Up to 1	0	0	Up to 1	Up to 1
Psychiatric Nurse Practitioner or Psychiatrist	Up to .06	0	0	Up to .06	Up to .06
Outreach Worker	Up to 1	0	0	Up to 1	Up to 1
Critical Time Intervention Director/Supervisor	Up to 1	0	1	Up to 1	Up to 1
Critical Time Intervention Coach	Up to 6	0	4	Up to 6	Up to 6
Care Transitions Administrative Support Worker	Up to 1	0	1	Up to 1	Up to 1
Behavioral Health Workforce Director	Up to 1	0	1	Up to 1	Up to 1
Behavioral Health Workforce Administrative Support Worker	Up to 1	0	0	Up to 1	Up to 1

* In the initial submission from July 2017, Program Coordinator was incorrectly listed twice in the table. This error was found following the submission and corrected for the current submission.

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

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

The Network4Health A1 project budget submitted as part of the July Semi-Annual Report and was approved in October 2017, is shown below.

A1 WORKFORCE TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
A1: Revenue (New)	\$1,693,350	\$1,693,350	\$1,073,520	\$715,680
A1: Revenue (Rollover)		\$533,578	\$697,816	\$285,807
Total Revenue	\$1,693,350	\$2,226,928	\$1,771,336	\$1,001,487

Recruit	\$549,500	\$474,000	\$474,000	\$257,000
Training/Development	\$515,712	\$872,292	\$823,301	\$550,689
Salaries (Salary, benefits, and travel)	\$87,500	\$180,250	\$185,658	\$191,228
Technology (Computer, phone, software)	\$7,060	\$2,570	\$2,570	\$2,570
Subtotal	\$1,159,772	\$1,529,112	\$1,485,529	\$1,001,487
Variation to Budget (Transfer Funds to Proceeding Year)	\$533,578	\$697,816	\$285,807	

At that time of the first installment payment to Network4Health in November, it was noted that the total revenue provided for all project budgets was slightly increased over expected. Network4Health had anticipated that the State would be distributing \$26,500,000 in available funding for CY 2017. However, the State distributed funding based on \$27,000,000 in available funding, impacting 2017 and the following 3 calendar years. The total available funds for the four year period remain the same. We have adjusted revenue projections based on the revised distribution formula and have made revisions to anticipated CY 18, 19, 20 budgets as reflected below:

A1 WORKFORCE TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual Expenses Posted	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
A1: Revenue (New)	\$1,725,089	\$1,725,089	\$1,035,053	\$715,592
A1: Revenue (Rollover)		\$1,687,873	\$1,502,763	\$671,204
Total Revenue	\$1,725,089	\$3,412,962	\$2,537,816	\$1,386,796
Recruit		\$657,167	\$657,166	\$440,166
Training/Development	\$20,527	\$1,037,354	\$988,362	\$715,750
Salaries (Salary, benefits, and travel)	\$14,768	\$204,494	\$209,901	\$215,471

Occupancy Costs		\$6,900	\$6,900	\$6,900
Technology (Computer, phone, software)	\$1,921	\$4,284	\$4,283	\$4,283
Subtotal	\$37,216	\$1,910,199	\$1,866,612	\$1,382,570
Variation to Budget (Transfer Funds to Proceeding Year)	\$1,687,873	\$1,502,763	\$671,204	\$4226

Our CY 2017 planned expenses were developed assuming a full six months of operations. Recruitment for the program director began in July with the position being filled full time in November. The administrative support position is in the process of being recruited but not hired. The total expense paid during the reporting period was \$37,215.81. These expenses include salary, benefits and technology to support the Workforce Development project and training and education that was made available to our partner organizations across the region. Additional expenses went to support the project specific trainings for both the Care Transitions and Co-occurring Disorders projects.

Network4Health anticipates that all planned expenses for CY2017 will be incurred in years 2018-2020, in the expense categories originally appearing in the budget. Our July submission did not contemplate an occupancy expense for this project. A new expense line has been added for this in CY 2018, 2019 and 2020 in the amount of \$6,900 annually.

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, <i>Federally Qualified Health Center, Non-CMHC Mental Health Provider, Primary Care Provider</i>	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
Bhutanese Community of NH	Community-Based Organization providing social and support services	A1, A2
Catholic Charities NH	Other, <i>Non CMHC mental health provider</i>	A1, A2
Center for Life Management	MHC, <i>SUD</i>	A1, A2, B1, C1, E4

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
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 Manchester/Bedford	<i>Primary Care Provider</i>	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 System	Hospital, Primary care provider, Non CMHC Mental health provider, SUD	A1, A2, B1, C1, D3, E4,
Families in Transition	Community-Based Organization providing social and support services, SUD	A1, A2, B1, E4
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
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	Federally Qualified Health Center	A1, A2, B1, E4
Manchester Housing and Redevelopment Authority	Other	A1, A2

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Manchester School District	Other	A1, A2
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
Serenity Place ¹	SUD Treatment	A1, A2, B1, D3, E4
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
St. Joseph Community Services, Inc.	Community Based Organization providing social services and supports	A1, A2
The Mental Health Center of Greater Manchester	MHC, SUD	A1, A2, B1, C1, E4,
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.

A1-9. Project Scoring: IDN Workforce Process Milestones

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

¹ Serenity Place was placed in receivership in December 2017, but was an important key partner for the vast majority of this reporting period.

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				
						M	T	W	T
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				
4		Recruit 1 BH Workforce Administrative Support Worker	132 days	Sat 7/1/17	Mon 1/1/18				
5		Recruit 1 HIT Analyst/Trainer	132 days	Sat 7/1/17	Mon 1/1/18				
6		Recruit 1 Integrated Healthcare Clinical Director	132 days	Sat 7/1/17	Mon 1/1/18				
7		Recruit 1 Critical Time Intervention Director	132 days	Sat 7/1/17	Mon 1/1/18				
8		Recruit 1 Care Transitions Administrative Support Worker	132 days	Sat 7/1/17	Mon 1/1/18				
9		Recruit 6 Critical Time Intervention Coaches	132 days	Sat 7/1/17	Mon 1/1/18				
10		Recruit 1 Co-occurring Disorders Clinical Director	132 days	Sat 7/1/17	Mon 1/1/18				
11		Recruit 3 Dual Diagnosis Capability Assessors	132 days	Sat 7/1/17	Mon 1/1/18				
12		Recruit Program Coordinator (D3)	132 days	Sat 7/1/17	Mon 1/1/18				
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				
15		Assess need to recruit 1.5 Innovation Consultants	131 days	Mon 1/1/18	Sat 6/30/18				

Project: BH Workforce PP
Date: Tue 1/23/18

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				
						M	T	W	T
16		Assess need to recruit 5 Community Health Workers	131 days	Mon 1/1/18	Sat 6/30/18				
17		Assess need to recruit Mental Health Clinician	131 days	Mon 1/1/18	Sat 6/30/18				
18		Assess need to recruit Substance Use Disorder Clinician	131 days	Mon 1/1/18	Sat 6/30/18				
19		Assess need to recruit Clinical Case Manager	131 days	Mon 1/1/18	Sat 6/30/18				
20		Assess need to recruit Nurse	131 days	Mon 1/1/18	Sat 6/30/18				
21		Assess need to recruit Nurse Practitioner or Psychiatrist	131 days	Mon 1/1/18	Sat 6/30/18				
22		Recruit 1 additional HIT Analyst/Trainer	130 days	Mon 1/1/18	Sat 6/30/18				
23		Recruit Peer Support Specialist	130 days	Mon 1/1/18	Sat 6/30/18				
24		Recruit Outreach Worker	130 days	Mon 1/1/18	Sat 6/30/18				
25		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18				
26		Assess turnover and additional recruitment needs of N4H teams	132 days	Sun 7/1/18	Mon 12/31/18				
27		Revise recruitment plan to include additional positions needed based on most current assessment	132 days	Sun 7/1/18	Mon 12/31/18				
28		Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18				
29		Assess turnover and additional recruitment needs of N4H teams	130 days	Tue 1/1/19	Sun 6/30/19				
30		Revise recruitment plan to include additional positions needed based on most current assessment	130 days	Tue 1/1/19	Sun 6/30/19				

Project: BH Workforce PP Date: Tue 1/23/18	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				
						M	T	W	T
31		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19				
32		Assess turnover and additional recruitment needs of N4H teams	132 days	Mon 7/1/19	Tue 12/31/19				
33		Revise recruitment plan to include additional positions needed based on most current assessment	132 days	Mon 7/1/19	Tue 12/31/19				
34		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19				
35		Assess turnover and additional recruitment needs of N4H teams	130 days	Wed 1/1/20	Tue 6/30/20				
36		Revise recruitment plan to include additional 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 additional recruitment needs of N4H teams	132 days	Wed 7/1/20	Thu 12/31/20				
39		Revise recruitment plan to include additional positions needed based on most current assessment	132 days	Wed 7/1/20	Thu 12/31/20				
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				
43		Survey N4H partners to identify which partners currently offer trainings needed	131 days	Sat 7/1/17	Sun 12/31/17				
44		Develop training plan based on needs, requests and retention efforts	131 days	Sat 7/1/17	Sun 12/31/17				
45		Begin implementation of training plan	131 days	Sat 7/1/17	Sun 12/31/17				
46		Critical Time Intervention worker training for Coaches	131 days	Sat 7/1/17	Sun 12/31/17				

Project: BH Workforce PP
Date: Tue 1/23/18

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				
						M	T	W	T
47		Critical Time Intervention training for Director	131 days	Sat 7/1/17	Sun 12/31/17				
48		Critical Time Intervention Community of Practice meetings	131 days	Sat 7/1/17	Sun 12/31/17				
49		Case Western Reserve training	131 days	Sat 7/1/17	Sun 12/31/17				
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				
52		Critical Time Intervention Community of Practice meetings	131 days	Mon 1/1/18	Sat 6/30/18				
53		HIT training in CMT	131 days	Mon 1/1/18	Sat 6/30/18				
54		Case Western Reserve training	131 days	Mon 1/1/18	Sat 6/30/18				
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				
57		Critical Time Intervention Community of Practice meetings	132 days	Sun 7/1/18	Mon 12/31/18				
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				
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				
62		Revise training plan based on most current assessment	132 days	Mon 7/1/19	Tue 12/31/19				

Project: BH Workforce PP
Date: Tue 1/23/18

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				
						M	T	W	T
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				
65		Revise training plan based on most current assessment	130 days	Wed 1/1/20	Tue 6/30/20				
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				
68		Revise training plan based on most current assessment	132 days	Wed 7/1/20	Thu 12/31/20				
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				
72		Align recruitment plan with targeted positions	132 days	Sat 7/1/17	Sun 12/31/17				
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				
75		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18				
76		Perform updated gap analysis of BH positions in region 4	132 days	Sun 7/1/18	Mon 12/31/18				
77		Reassess targeted positions based on most current gap analysis	132 days	Sun 7/1/18	Mon 12/31/18				
78		Revise recruitment plan for targeted positions based on most current gap analysis	132 days	Sun 7/1/18	Mon 12/31/18				

Project: BH Workforce PP Date: Tue 1/23/18	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				
						M	T	W	T
79		Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18				
80		Assess and revise recruitment plan based on feedback from N4H partners	130 days	Tue 1/1/19	Sun 6/30/19				
81		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19				
82		Perform updated gap analysis	132 days	Mon 7/1/19	Tue 12/31/19				
83		Reassess targeted positions based on most current gap analysis	132 days	Mon 7/1/19	Tue 12/31/19				
84		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19				
85		Assess and revise recruitment plan based on feedback from N4H partners	130 days	Wed 1/1/20	Tue 6/30/20				
86		Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20				
87		Finalize and move to close open recruitment of positions with N4H partners	132 days	Wed 7/1/20	Thu 12/31/20				
88		Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20				
89		Statewide BH Workforce	915 days	Sat 7/1/17	Thu 12/31/20				
90		Approve Statewide Implementation Plan	1 day	Mon 7/3/17	Mon 7/3/17				
91		Sign attestation agreeing to Statewide Implementation Plan	20 days	Tue 7/4/17	Mon 7/31/17				
92		Participate in establishing monthly work team meetings	46 days	Sat 7/1/17	Fri 9/1/17				
93		Attend monthly work team meetings as appropriate	132 days	Sat 7/1/17	Mon 1/1/18				
94		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				

Project: BH Workforce PP Date: Tue 1/23/18	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				
						M	T	W	T
95		Milestone reporting period	0 days	Sun 12/31/17	Sun 12/31/17				
96		Reasses participation requested by the Statewide BH Workforce and adjust accordingly	23 days	Mon 1/1/18	Wed 1/31/18				
97		Attend monthly work team meetings as appropriate	131 days	Mon 1/1/18	Sat 6/30/18				
98		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				
99		Milestone reporting period	0 days	Sat 6/30/18	Sat 6/30/18				
100		Reasses participation requested by the Statewide BH Workforce and adjust accordingly	22 days	Sun 7/1/18	Mon 7/30/18				
101		Attend monthly work team meetings as appropriate	132 days	Sun 7/1/18	Mon 12/31/18				
102		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				
103		Milestone reporting period	0 days	Mon 12/31/18	Mon 12/31/18				
104		Reasses participation requested by the Statewide BH Workforce and adjust accordingly	23 days	Tue 1/1/19	Thu 1/31/19				
105		Attend monthly work team meetings as appropriate	130 days	Tue 1/1/19	Sun 6/30/19				
106		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Tue 1/1/19	Sun 6/30/19				
107		Milestone reporting period	0 days	Sun 6/30/19	Sun 6/30/19				
108		Reasses participation requested by the Statewide BH Workforce and adjust accordingly	22 days	Mon 7/1/19	Tue 7/30/19				
109		Attend monthly work team meetings as appropriate	133 days	Sun 6/30/19	Tue 12/31/19				
110		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	133 days	Sun 6/30/19	Tue 12/31/19				

Project: BH Workforce PP Date: Tue 1/23/18	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				
						M	T	W	T
111		Milestone reporting period	0 days	Tue 12/31/19	Tue 12/31/19				
112		Reasses participation requested by the Statewide BH Workforce and adjust accordingly	23 days	Wed 1/1/20	Fri 1/31/20				
113		Attend monthly work team meetings as appropriate	130 days	Wed 1/1/20	Tue 6/30/20				
114		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	130 days	Wed 1/1/20	Tue 6/30/20				
115		Milestone reporting period	0 days	Tue 6/30/20	Tue 6/30/20				
116		Reasses participation requested by the Statewide BH Workforce and adjust accordingly	22 days	Wed 7/1/20	Thu 7/30/20				
117		Attend monthly work team meetings as appropriate	132 days	Wed 7/1/20	Thu 12/31/20				
118		Attend quarterly Statewide Workforce Steering meetings to review Statewide Implementation Plan activities	132 days	Wed 7/1/20	Thu 12/31/20				
119		Milestone reporting period	0 days	Thu 12/31/20	Thu 12/31/20				

Project: BH Workforce PP
Date: Tue 1/23/18

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.

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

Network4Health's partners continue to identify strategies to improve the gaps identified through IDN level 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 organizations and 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 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.

DIRECT Secure Messaging

Network4Health currently has 9 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.

As shown in the A2 project plan, Network4Health has made progress towards selecting a vendor, and is on track for final vendor selection and approval, as well as the signing of partner contracts prior to the end of May 2018. Following vendor selection and implementation, Network4Health partners will receive training in the product by the end of 2018. This will allow for full referral functionality amongst Network4Health's 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 EDIE and PreManage Community products. In addition, Catholic Medical Center as a Network4Health partner, signed a User Agreement with CMT which allowed them to begin implementation of a Catholic Medical Center admission, discharge and transfer (ADT) data feed to the CMT platform for notification to partners across New Hampshire. The Catholic Medical Center IT team is in the final stages of testing for both the sending of ADT data to the CMT platform and the receipt of event notifications from the CMT platform (as provided by other participating New Hampshire hospitals). 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 and is currently being tested. Network4Health's HIT Director is currently working with the Catholic Medical Center 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 EDIE portal to care coordination staff 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 January 2018.

Both the Elliot Health System and Parkland Hospital received the CMT User Agreement in Q4 2017. Elliot Health System notified Network4Health that due to a backlog in their compliance team, there would be a significant delay in contract execution for CMT. We hope to have contract execution by Elliot Health System to participate in sending an ADT feed to the CMT platform in Q1 2018. Despite

multiple meetings and communications, Network4Health has not received a response from Parkland Medical Center regarding their intent to participate in the CMT implementation. Network4Health is continuing to engage Parkland Medical Center as a participating Network4Health partner.

In addition to utilizing CMT's event notification functionality, Network4Health has finalized our intent to utilize CMT for Shared Care Planning across our IDN. Network4Health has put all other care coordination tool evaluations, such as Eccovia ClientTrack and Allscripts CareDirector products, on hold at this time. A majority of our primary care and behavioral health partners currently utilize a care management tool, typically within the constructs of their EHR. Network4Health did not receive sufficient partner interest in adding an additional care management tool to our partners' busy workflows at this time. We will instead focus our attention on the development of integrated workflows to support sharing of existing care plans and partner collaboration in treatment. In addition, with the Comprehensive Core Standardized Assessment (CCSA) guidance provided by NH DHHS in December 2017, it was clarified that only primary care and behavioral health providers can complete a CCSA, thus negating the need for community support partner organizations to have access to a CCSA tool. 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. Network4Health is exploring closed loop referral tools in combination with the expansion of Direct secure messaging to facilitate referrals that result from a completed CCSA. We hope to incentivize partner engagement in the limited care planning functionality available through CMT as an initial step in introducing Shared Care Plans in our region through our B1 Integrated Healthcare project.

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. To support issue resolution for data-related questions, Network4Health took the lead in organizing a Data Issue Resolution Meeting in December 2017. The 4-hour cross-IDN and NH DHHS meeting collaborated to resolve a list of the key issues blocking organizations from moving forward with the data aggregator service. While significant progress was made, 14 issues remain open. The list was communicated to all IDN partners and the DHHS waiver team for continued collaboration at the bi-weekly Data Meetings hosted by DHHS. As indicated and in-alignment with other IDNs, Catholic Medical Center as the Network4Health administrative lead is engaged in contract negotiations with MAeHC for IDN data aggregator services. Due to the sensitive nature of the Personal Health Information (PHI) required for performance measurement calculation, the contracting process has been lengthy and challenging. We expect Catholic Medical Center to have a fully executed contract with MAeHC by the end of January 2018. To follow contract execution, Network4Health has created a sub-contract 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. Due to our current experience with contracting,

Network4Health is unclear which partners will be able to participate in the initial MAeHC implementation and April 2018 data reporting for the Assess_Screen.01 measure. At a minimum, Network4Health hopes to initiate MAeHC implementation activities with Catholic Medical Center and be able to report their data for April 2018. Network4Health and our data partners continue to work closely with MAeHC to prepare for a speedy implementation when contract execution is complete.

In our initial implementation plan submission, Network4Health had hoped the data aggregator service would allow different participating organizations within Region 4 to not only share data for the required EHR-calculated performance measures, but also a larger application as a hub to share data across partners. 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. As part of their B1 Integration Enhancement Plan, Network4Health partners will 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 captures and sends discrete, structured patient data into the electronic health record or can produce a PDF formatted document to support our non EHR partners thus reducing the time and resources needed to support manual data entry.

Network4Health plans to move forward with IDN level contracting to provide Network4Health partners with access to PatientLink when selected as part of their B1 Integration Enhancement Plan. Proof of concept work is already in progress at Catholic Medical Center to demonstrate patient intake forms that would cover the required CCSA domains through an existing PatientLink partner contract.

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 be supporting the implementation of Par8o. With Par8o, decision support including network participation, plan design, provider clinical preferences, and appointment availability is visible to referring providers and staff right 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 on track to complete our RFP process and have a final vendor selected in the first quarter of 2018. As detailed in the A2 project plan, Network4Healths expects contract signatures, implementation and training to each begin in April 2018 and continue through project completion in mid 2019.

Workforce

In October 2017, [REDACTED] joined Network4Health as the HIT Director. [REDACTED] has both clinical and HIT experience working as an Emergency Department Nurse, a Chief Nurse Information Officer (CNIO) and most recently working with a large EHR vendor. She brings a valuable perspective to our partner organizations and is highly engaged with both our HIT and Integrated Care project participants. Network4Health has put any further hiring of an HIT systems analyst on hold until vendor contracting and Network4Health partner commitments to B1 Integration Enhancement Plans are complete and the work-stream for additional support staff is clear.

Network4Health has updated and streamlined the HIT project plan (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	X	
Aim 3: Enroll ENS subscribers, train, and transmit notifications via CMT		X	X
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.

Network4Health's progress towards its target is in alignment with its project timeline.

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 37 practices by 12/31/18	9		
The number of participating partners who acquire the Event Notification System (ENS)	17 of 37 practices by 12/31/18	1		

Performance Measure Name	Target	Progress Toward Target		
The number of participating partners who acquire the Shared Care Plan (SCP)	17 of 37 practices By 12/31/18	0		
The number of participating partners who implement and receive training for DIRECT Secure Messaging	17 of 37 practices by 12/31/18	0		
The number of participating partners who implement and receive training for the Event Notification System (ENS)	17 of 37 practices by 12/31/18	0		
The number of participating partners who implement and receive training for the Shared Care Plan (SCP)	17 of 37 practices By 12/31/19	0		
The number of participating partners who contribute to DIRECT Secure Messaging	17 of 37 practices by 12/31/18	0		
The number of participating partners who contribute to Event Notification System (ENS)	10 of 37 practices by 12/31/18	1		
The number of participating partners who contribute to a Shared Care Plan (SCP)	10 of 37 practices By 12/31/19	0		
The number of participating partners who use DIRECT Secure Messaging	10 of 37 practices by 12/31/19	0		
The number of participating partners who use an Event Notification System (ENS)	10 of 37 practices by 12/31/19	0		
The number of participating partners who use a Shared Care Plan (SCP)	5 of 37 practices By 12/31/19	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		
Application Analyst	Up to 1	0	0		

*This is a change in job title to support the job description and scope of work.

A2-6. IDN HIT: Budget

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

The following budget was submitted as part of the Network4Health Semi Annual Report dated October 3, 2017.

A2 HIT TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
A2 Revenue (New)	\$1,693,350	\$1,693,350	\$1,073,520	\$715,680
A2 Revenue (Rollover)		\$151,988	\$927,571	\$656,261
Total Revenue	\$1,693,350	\$1,845,338	\$2,001,091	\$1,371,941
PreManage ED (\$0.50 per ED visit per year) - Software License	\$78,407	\$80,759	\$83,181	\$85,677
PreManage Community (\$0.12 per Medicaid member per month) - Software License	\$68,484	\$70,538	\$72,654	\$74,834
PreManage PMDP (\$50 / provider/yr, ~200 providers) - Software License	\$10,000	\$10,300	\$10,609	\$10,927
Client Track Phase 1 Implementation (Care Plan Tool)	\$214,500			
Client Track Recurring	\$273,000	\$256,000	\$263,680	\$271,590
Client Track Phase 2 Implementation	\$242,500			
Client Track Portal	\$50,000	\$51,500	\$53,045	\$54,636
Direct secure messaging (\$750*30) - Software License	\$22,500	\$23,175	\$23,870	\$24,586
Data aggregator implementation	\$57,513			
Data aggregator Analytics	\$74,190	\$76,416	\$78,708	\$81,069
Data aggregator Data Source Implementation	\$208,929			
Data aggregator DMaaS annual support	\$31,339	\$32,279	\$33,248	\$34,245
Query Based Exchange			\$400,000	\$400,000
Secure Data Storage	\$50,000	\$51,500	\$53,045	\$54,636
EMR Integration	\$50,000			
Contingency Fund		\$49,000	\$50,000	\$50,000
Internet Connectivity	\$10,000	\$10,300	\$10,609	\$10,927
	\$100,000	\$206,000	\$212,180	\$218,545
Subtotal	\$1,541,362	\$917,767	\$1,344,830	\$1,371,674
Variation to Budget (Transfer Funds to Proceeding Year)	\$151,988	\$927,571	\$656,261	\$267

As shown in the budget below, the total expense paid from the A2 project budget during the reporting period was \$12,190.25, significantly less than estimated for this time period. These expenses include salary and benefits and technology. Recruitment for the program director began in July with the position being filled full time in November 2017. Network4Health anticipates that all planned expenses

for CY2017 will be incurred in years 2018-2020 years in the expense categories originally appearing in the budget

Budget Modifications 2018 -2020

The A2 project budget line items have been updated to align with the evolution of our HIT approach as described in the project narrative in section A2-3. The following line items, for which no actual spending occurred, have been removed and funds have been re-allocated in the budget:

- Client Track – All funds related to the Eccovia Client Track have been re-allocated to the current Network4Health HIT tools identified in section A2-3. The majority of the funds have been transferred to support the B1 Integration Enhancement Plans. Network4Health anticipates that the additional HIT needs for behavioral health/primary care integration will be project or organization specific and will be identified and funded through the Integration Enhancement Plans.
- Query Based Exchange – Based on the current plans for data submission to MAeHC and the significant contracting and privacy discussions in progress, we do not currently anticipate the moving forward with an extensive Query Based Exchange effort. We have re-allocated these funds to support our current Network4Health HIT tools identified in section A2-3 and supporting HIT across our integrated care partners. Network4Health currently anticipates Secure Data Storage occurring with MAeHC or through PatientLink funds. We have re-allocated these funds to support our current Network4Health HIT tools identified in section A2-3.

The following line items have been added to the 2018 - 2020 budget:

- B1 Integration Enhancement Plan Support Funds – Network4Health has identified the need to have significant funds available to support the HIT needs of our B1 Integrated Healthcare project partners. Partners are identifying their needs to implement all requirements of the B1 Integrated Healthcare project, including HIT, in their Integration Enhancement Plans. We anticipate significant HIT needs will be identified in the Integration Enhancement Plans submitted for our cohort 1 and cohort 2 partners in 2018 including, but not limited to care planning tool licensing, other HIT tool licensing, implementation fees, HIT training, HIT consulting, existing tool development or customization costs. We have also included participation offset fees for partners IT resources to participate in meetings, planning and implementation efforts for the targeted HIT solutions. Our partners have clearly communicated the burden to their teams to rollout new solutions.
- Referrals – As described in the A2-3 narrative, Network4Health is evaluating and planning to offer a closed loop referral system, Par80, to Network4Health partners. Funds have been allocated to support estimated licensing and implementation fees for this tool.
- CCSA Implementation - As described in the A2-3 narrative, Network4Health will be offering organizations implementing a Comprehensive Core Standardized Assessment (CCSA), the option of utilizing PatientLink to implement a paper or tablet-based intake forms for collection and reporting of CCSA domain screening data or modifying their existing EHR to allow for collection and reporting. Funds are thus allocated for patient link and EHR technical assistance.

The following line items, for which no actual spending occurred in 2017, have been modified in the budget:

- Secure Messaging – The secure messaging budget has been updated to reflect our current understanding of both licensing and implementation fees.

- **Data Aggregator** – The data aggregator line items have been updated based on the negotiated contract between Catholic Medical Center, the Network4Health administrative lead, and Massachusetts eHealth Collaborative (MAeHC). Network4Health has also included additional funds to support custom reporting or consulting with MAeHC.

In addition to the project changes, the budget below has also been modified to reflect the fact that the total revenue provided for all project budgets was slightly increased over expected. Network4Health had anticipated that the State would be distributing \$26,500,000 in available funding for CY 2017. However, the State distributed funding based on \$27,000,000 in available funding, impacting 2017 and the following 3 calendar years. The total available funds for the four year period remain the same. We have adjusted revenue projections based on the revised distribution formula.

A2 HIT TRANSFORMATON FUNDS	CY 2017 (Yr2) Actuals	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
A2 Revenue (New)	\$1,725,089	\$1,725,089	\$1,035,053	\$715,592
A2 Revenue (Rollover)		\$1,712,899	\$1,051,602	\$516,010
Total Revenue	\$1,725,089	\$3,437,988	\$2,086,655	\$1,231,602
Event Notification System and Shared Care Plan				
PreManage ED - Annual Subscription for CMC, Elliot, Parkland		\$159,166	\$83,181	\$85,677
PreManage Primary/ Community (\$0.12 per Medicaid member per month) - Software License		\$90,000	\$90,000	\$90,000
PreManage PMDP (\$50 / provider/yr, ~200 providers) - Software License		\$20,300	\$10,609	\$10,927
Client Track Phase 1 (Software license & implementation fees)				
Client Track Phase 1 (Software license & implementation fees)				
Client Track Recurring (Software)				
Client Track Phase 2 (Software license & implementation fees)				
Client Portal (Software licensing)				
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.)		\$800,000	\$500,000	\$200,000
Participation Offset		\$225,000	\$125,000	\$125,000
Secure Messaging				
Direct secure messaging (\$750*30) - Software License		\$25,000	\$25,000	\$25,000

Data Aggregator				
Data Aggregator Implementation		\$223,245		
Data Aggregator Analytics				
Data Aggregator Source Implementation				
Data aggregator DMaaS annual support				
Data Aggregator Annual Service Fees		\$62,675	\$62,675	\$62,675
Data Aggregator - Customizations, Consulting, Custom Reporting (estimate)		\$100,000	\$100,000	\$100,000
Secure Data Storage				
Referrals				
Closed Loop Referral System		\$150,000	\$100,000	\$100,000
CCSA Implementation				
Patient Link Implementation and Licensing Costs		\$150,000	\$100,000	\$75,000
EMR Integration (Technical Assistance Fund)		\$55,000	\$50,000	\$25,000
Other				
Contingency Fund	\$2,170	\$100,000	\$100,000	\$100,000
Internet Connectivity (Setup and Monthly Fees)		\$20,000	\$12,000	\$12,000
[REDACTED]	\$10,020	\$206,000	\$212,180	\$218,545
Subtotal	\$12,190	\$2,386,386	\$1,570,645	\$1,229,824
Variation to Budget (Transfer Funds to Proceeding Year)	\$1,712,899	\$1,051,602	\$516,010	\$1,777

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

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

Organization	Type
<i>Catholic Medical Center</i>	<i>Hospital/PCP/ FQHC/MH</i>
<i>Catholic Medical Center (Hospital)</i>	
<i>Healthcare for the Homeless (FQHC)</i>	
<i>CMC Behavioral Health</i>	
<i>Bedford Center Internal Medicine and Pediatrics (New name. Form name: Family Health and Wellness Center at Bedford)</i>	
<i>Highlander Way Internal Medicine</i>	
<i>Hooksett Internal Medicine</i>	
<i>Willowbend Family Practice</i>	
<i>Family Physicians of Manchester</i>	
<i>Goffstown Family Practice</i>	
<i>Granite State Internal Medicine</i>	
<i>Highlander Way Internal Medicine</i>	
<i>Lakeview Internal Medicine</i>	
<i>Queen City Medical Associates</i>	
<i>Webster Street Internal Medicine</i>	

<i>Center for Life Management</i>	<i>CMHC</i>
<i>Dartmouth Hitchcock Clinic- Manchester and Bedford</i>	<i>PCP</i>
<i>Elliot Health System</i> <i>Elliot Hospital</i> <i>Elliot Primary Care at Bedford</i> <i>Pediatric Health Associates, Bedford</i> <i>Doctors Park Pediatrics, Manchester</i> <i>Pediatric Health Associates, Manchester</i> <i>Elliot Behavioral Health Services</i> <i>Elliot Pediatrics and Primary Care at Riverside</i> <i>Elliot Family Medicine, Hooksett</i> <i>Dr. Kenneth D. Thomas</i> <i>Elliot Family Medicine at Goffstown</i> <i>Elliot Family Medicine at Windham</i> <i>Elliot Pediatrics at Windham</i> <i>Elliot Primary Care at Londonderry</i> <i>Elliott Internal Medicine at Londonderry</i> <i>Senior Health Primary Care</i> <i>Briarwood Primary Care</i> <i>Derryfield Medical Group</i>	<i>Hosp/PCP</i>
<i>Easter Seals NH (Farnum Center)</i>	<i>SUD/CBSSO</i>
<i>Families in Transition</i>	<i>Res/SUD</i>
<i>Manchester Community Health Center</i>	<i>FQHC/PCP/BH</i>
<i>The Mental Health Center of Greater Manchester</i>	<i>CMHC</i>
<i>Serenity Place*</i>	<i>SUD</i>

**Participation on hold as organization is under-receivership*

A2-8. IDN HIT. Data Agreement

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

Data sharing agreements are inherent in the implementation of the infrastructure products that Network4Health is deploying. There are not separate data sharing agreements yet signed, but they will be part of the implementation for all tools, if required. To support the implementation of the Massachusetts eHealth Collaborative (MAeHC) data aggregator service, Network4Health’s legal council is creating a data sub-contract and Business Associates Agreement for all data sharing partners to sign with Catholic Medical Center, the Network4Health administrative lead organization. Catholic Medical Center is in the final stage of contract execution with MAeHC on behalf of Network4Health. As part of the implementation of Collective Medical Technologies (CMT), participating partner organizations will sign individual user agreements to provide ADT information.

The execution of contracts between MAeHC and Catholic Medical Center, as the Network4Health lead entity, has been more complicated than anticipated in early project planning. We have seen significant progress in recent weeks and expect full execution of this contract in January 2018. Therefore, the table

below lists all Network4Health partners but indicates they have not yet signed an agreement, but adds a column to show expected date by which the data sharing agreement will be sign.

Organization Name	Data Sharing Agreement Signed Y/N	Anticipated Completion
American Medical Response	N	June 2018
Ascentria Care Alliance	N	June 2018
Bhutanese Community of NH	N	June 2018
Catholic Charities of NH	N	June 2018
Catholic Medical Center	N	January 2018
Center for Life Management	N	May 2018
Child and Family Services	N	June 2018
City of Manchester Health Department	N	June 2018
Community Crossroads	N	June 2018
Crotched Mountain	N	June 2018
Dartmouth-Hitchcock Clinic-Manchester	N	May 2018
Derry Friendship Center	N	June 2018
Easter Seals New Hampshire	N	June 2018
Elliot Health System	N	May 2018
Families in Transition	N	May 2018
Goodwill Industries of Norther NE	N	June 2018
Granite Pathways (FedCap)	N	June 2018
Granite State Independent Living	N	July 2018
Granite United Way	N	July 2018
Greater Derry Community Health Services, Inc.	N	July 2018
Hillsborough County	N	July 2018
Home Health and Hospice Care	N	July 2018
HOPE for New Hampshire Recovery	N	July 2018

Organization Name	Data Sharing Agreement Signed Y/N	Anticipated Completion
International Institute of NE	N	July 2018
Life Coping Inc.	N	July 2018
Makin' It Happen	N	July 2018
Manchester Community Health Center	N	May 2018
Manchester Housing & Redevelopment Authority	N	July 2018
Manchester School District	N	July 2018
National Alliance on Mental Illness (NAMI NH)	N	July 2018
New Horizons for New Hampshire	N	May 2018
New Hampshire Legal Assistance	N	July 2018
On the Road to Wellness	N	July 2018
Parkland Medical Center	N	TBD
Pastoral Counseling Services	N	July 2018
Rockingham County	N	July 2018
Rockingham ServiceLink Resource Center	N	July 2018
St. Joseph Community Services	N	July 2018
Serenity Place*	N	N/A
Southern NH Services	N	July 2018
The Mental Health Center of Greater Manchester	N	May 2018
The Moore Center	N	July 2018
The Upper Room	N	July 2018

*Serenity Place has entered into receivership as of December 2017 and as such will not be participating as a Network4Health partner going forward.

A2-9. Project Scoring: IDN HIT Process Milestones

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

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

A2-HIT-12312017

Task Name	Duration	Start	Finish	Predecessors	% Complete
1 <input type="checkbox"/> HIT Implementation Plan	1065d	01/02/17	01/29/21		21%
2 <input type="checkbox"/> State Level HIT Planning	390d	01/02/17	06/29/18		100%
3 Participate in Statewide HIT Planning	108d	01/02/17	05/31/17		100%
4 Receive Statewide HIT Report (informs IDN 4 Implementation Plan)	1d	06/01/17	06/01/17		100%
5 Create IDN 4 HIT Implementation Plan	130d	01/01/18	06/29/18		100%
6 <input type="checkbox"/> Network 4 Health/IDN 4 HIT Implementation Plan	431d	09/01/17	04/26/19		6%
7 <input type="checkbox"/> Event Notification and Shared Care Planning (CMT)	363d	09/20/17	02/08/19		14%
8 Sign IDN Support Contract w/ CMT (Network 4 Health/CMC Admin lead)	1d	09/20/17	09/20/17		100%
9 <input type="checkbox"/> CMT Master Service Agreement and PreManage Service Orders	138d	09/20/17	03/30/18		1%
10 CMC Signed Agreement	1d	09/20/17	09/20/17		100%
11 Elliot Signed Agreement	85d	12/04/17	03/30/18		
12 Parkland Signed Agreement	85d	12/04/17	03/30/18		
13 <input type="checkbox"/> ADT Feed Implementation to NH CMT PreManage Platform	202d	09/21/17	06/29/18		46%
14 CMC ADT feed Implementation, Testing and Go-Live	137d	09/21/17	03/30/18	10	90%
15 Elliot ADT feed Implementation, Testing and Go-Live	13w	04/02/18	06/29/18	11	
16 Parkland ADT feed Implementation, Testing and Go-Live	13w	04/02/18	06/29/18	12	
17 <input type="checkbox"/> Emergency Department Event Notifications (CMT PreManage EDIE)	111d	01/29/18	07/02/18		
18 <input type="checkbox"/> CMC Emergency Department	46d	01/29/18	04/02/18		
19 Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	10d	01/29/18	02/09/18	14FS -45d	
20 Implementation and Testing	25d	02/12/18	03/16/18	19	
21 Emergency Department Training	10d	03/19/18	03/30/18	20	
22 Go-Live	1d	04/02/18	04/02/18	21	
23 <input type="checkbox"/> Elliot Emergency Department	46d	04/30/18	07/02/18		
24 Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	10d	04/30/18	05/11/18	15FS -45d	
25 Implementation and Testing	25d	05/14/18	06/15/18	24	
26 Emergency Department Training	10d	06/18/18	06/29/18	25	
27 Go-Live	1d	07/02/18	07/02/18	26	
28 <input type="checkbox"/> Parkland Emergency Department	46d	04/30/18	07/02/18		
29 Implementation Approach Selection (Notification triggers; Notification mechanism: Printer, EHR Integration; Workflow Modifications)	10d	04/30/18	05/11/18	16FS -45d	
30 Implementation and Testing	25d	05/14/18	06/15/18	29	
31 Emergency Department Training	10d	06/18/18	06/29/18	30	
32 Go-Live	1d	07/02/18	07/02/18	31	
33 <input type="checkbox"/> Primary Care and BH Providers Event Notification (PreManage Community)	225d	04/02/18	02/08/19		
34 <input type="checkbox"/> Cohort 1 Participants - B1 Integrated Care Project	180d	04/02/18	12/07/18		
35 Sign CMT User Agreements	12w	04/02/18	06/22/18	14	
36 Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	16w	06/04/18	09/21/18	35FS -15d	
37 <input type="checkbox"/> Shared Cared Planning Implementation	120d	06/25/18	12/07/18		
38 Workflow	6w	06/25/18	08/03/18	35	
39 Training	12w	08/06/18	10/26/18	38	
40 Go Live	6w	10/29/18	12/07/18	39	
41 <input type="checkbox"/> Cohort 2 Participants - B1 Integrated Care Project	180d	06/04/18	02/08/19		
42 Sign CMT User Agreements	12w	06/04/18	08/24/18		
43 Event Notification Implementation: IT setup, workflow, admin setup, testing, training and Go-Live	16w	08/27/18	12/14/18	42	

Attachment_A2.3

Task Name	Duration	Start	Finish	Predecessors	% Complete
44 <input type="checkbox"/> Shared Cared Planning Implementation	120d	08/27/18	02/08/19		
45 Workflow	6w	08/27/18	10/05/18	42	
46 Training	12w	10/08/18	12/28/18	45	
47 Go Live	6w	12/31/18	02/08/19	46	
48 <input type="checkbox"/> Comprehensive Core Standardized Assessment (PatientLink or EHR Build)	360d	12/11/17	04/26/19		
49 <input type="checkbox"/> PatientLink	360d	12/11/17	04/26/19		
50 Proof of Concept (N4H and PatientLink - CMC existing contract)	12w	12/11/17	03/02/18		
51 Sign IDN Support Contract w/ PatientLink (Network 4 Health/CMC Admin lead)	4w	02/05/18	03/02/18		
52 <input type="checkbox"/> B1 Cohort 1	235d	02/05/18	12/28/18		
53 Identify Cohort 1 Integrated Care Patientlink Participants	4w	02/05/18	03/02/18		
54 B1 Cohort1 - Sign Participant Agreements w/ PatientLink (Partner Orgs)	16w	03/05/18	06/22/18	51	
55 Site Level Implementations: Requirements, Build, Testing, Training	15w	06/25/18	10/05/18	54	
56 Go-Live(s) and Data Collection (Modifications and Lessons Learned)	12w	10/08/18	12/28/18	55	
57 <input type="checkbox"/> B1 Cohort 2	215d	07/02/18	04/26/19		
58 Identify Cohort 2 Integrated Care Patientlink Participants	4w	07/02/18	07/27/18		
59 B1 Cohort2 - Sign Participant Agreements w/ PatientLink (Partner Orgs)	12w	07/30/18	10/19/18	58	
60 Site Level Implementations: Requirements, Build, Testing, Training	15w	10/22/18	02/01/19	59	
61 Go-Live(s) and Data Collection (Modifications and Lessons Learned)	12w	02/04/19	04/26/19	60	
62 <input type="checkbox"/> Data Aggregator Services (MAeHC)	325d	09/01/17	11/29/18		15%
63 Identify capable vendors	0	09/01/17	09/01/17		100%
64 Sign IDN Support Agreement	12w	11/03/17	01/25/18	63FS +45d	95%
65 CMC Denominator Submission	23d	01/26/18	02/27/18	64	
66 Sign Data Sharing Sub-Contracts with Network4Health Partners (begin implementation as contracts are signed)	24w	01/26/18	07/12/18	64	
67 Implementation, Testing, Go-Live (as contracts are signed)	38w	03/09/18	11/29/18	66SS +30d	
68 <input type="checkbox"/> Closed Loop Referral Tool (Par8o)	328d	01/01/18	04/03/19		
69 Validate vendor selection	43d	01/01/18	02/28/18		
70 Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	17w	03/01/18	06/27/18	69	
71 Identify Partner Organizations for Implementation	6w	03/01/18	04/11/18	70SS	
72 Sign Participant Agreements (Partner Orgs)	10w	06/28/18	09/05/18	70	
73 Configuration, Workflow and Implementation	16w	09/06/18	12/26/18	72	
74 Training	8w	12/27/18	02/20/19	73	
75 Go-Live(s)	6w	02/21/19	04/03/19	74	
76 <input type="checkbox"/> Direct Secure Messaging (MedAllies)	245d	01/01/18	12/07/18		
77 Validate vendor selection	60d	01/01/18	03/23/18		
78 Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	30d	03/26/18	05/04/18	77	
79 Identify Partner Organizations for Implementation (B1 Project - Cohort 2)	6w	05/07/18	06/15/18	78	
80 Sign Participant Agreements (Partner Orgs)	1w	06/18/18	06/22/18	79	
81 Configuration, Workflow and Implementation	8w	06/25/18	08/17/18	80	
82 Training	8w	08/20/18	10/12/18	81	
83 Go-Live(s)	8w	10/15/18	12/07/18	82	
84 <input type="checkbox"/> Process Milestones by Reporting Period	805d	12/01/17	12/31/20		0%
85 <input type="checkbox"/> Period ending June 30, 2017	0	06/29/18	06/29/18		100%
86 IDN 4 HIT Implementation Plan Complete	0	06/29/18	06/29/18		100%
87 <input type="checkbox"/> July - December 2017	15d	12/01/17	12/22/17		0%

Attachment_A2.3

Task Name	Duration	Start	Finish	Predecessors	% Complete
88 ED Premanage Network4Health Contract Signed	0	12/01/17	12/01/17		100%
89 ED Premanage Hospital User Agreements Signed	0	12/08/17	12/08/17		33%
90 CMC ADT feed in production	0	12/22/17	12/22/17		80%
91 January - June 2018	121d	01/12/18	06/29/18		0%
92 CMT ED PreManage: Elliot ADT feed in production	0	06/29/18	06/29/18	15	
93 CMT ED PreManage: Parkland ADT feed in production	0	06/29/18	06/29/18	16	
94 CMT PreManage Community User Agreements Signed	0	06/22/18	06/22/18	35	
95 Core Standardized Assessment Tool Vendor Selection Complete	0	03/02/18	03/02/18	51	
96 CMT ED PreManage: CMC Emergency Department Event Notification Go-Live	0	03/30/18	03/30/18	21	
97 Core Standardized Assessment Tool Vendor Contract Complete	0	03/02/18	03/02/18	51	
98 Core Standardized Assessment Training Complete Cohort 1 B1 Integrated Healthcare Participants	0	06/22/18	06/22/18	54	
99 Data Warehouse Vendor Selection Complete	0	01/12/18	01/12/18		100%
100 Data Warehouse Vendor Contract Complete	0	01/25/18	01/25/18	64	
101 Closed Loop Referral Tool: Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	1d	06/28/18	06/28/18	70	
102 Direct Secure Messaging Vendor: Sign IDN Support Contract (Network 4 Health/CMC Admin lead)	1d	05/07/18	05/07/18	78	
103 Direct Secure Messaging Vendor: Identify Partner Organizations for Implementation (B1 Project - Cohort 2)	1d	06/18/18	06/18/18	79	
104 July - December 2018	144d	07/02/18	01/18/19		
105 PROGRESS ASSMENT: Collect/evaluate feedback ENS message USERS	85d	09/24/18	01/18/19		
106 CMT ED PreManage: Elliot Emergency Department Event Notification Go-Live	0	07/02/18	07/02/18	27	
107 CMT PreManage Community: Event Notification Go-Live Cohort 1 B1 Integrated Healthcare Participants	1d	09/24/18	09/24/18	36	
108 CMT PreManage Community: Shared Care Plan Go-Live Cohort 1 B1 Integrated Healthcare Participants	1d	12/10/18	12/10/18	40	
109 CMT PreManage Community: Event Notification Go-Live Cohort 2 B1 Integrated Healthcare Participants	1d	12/17/18	12/17/18	43	
110 Core Standardized Assessment Go-Live(s) B1 Integrated Healthcare Participants	0	10/05/18	10/05/18	55	
111 Closed Loop Referral Tool: Sign Participant Agreements (Partner Orgs)	1d	09/06/18	09/06/18	72	
112 Closed Loop Referral Tool: Configuration, Workflow and Implementation	1d	12/27/18	12/27/18	73	
113 Data Aggregator Implementation, Testing, Go-Live (as partner sub-contracts are signed)	1d	11/30/18	11/30/18	67	
114 Direct Secure Messaging Vendor: Training Complete	1d	10/15/18	10/15/18	82	
115 Direct Secure Messaging Vendor: Go-Live(s) Complete	1d	12/10/18	12/10/18	83	
116 January - December 2019	100d	02/01/19	06/21/19		
117 PROGRESS ASSMENT: Collect/evaluate feedback CCSA USERS	60d	04/01/19	06/21/19		
118 CMT PreManage Community: Shared Care Plan Go-Live Cohort 1 B1 Integrated Healthcare Participants	1d	02/11/19	02/11/19	47	
119 Core Standardized Assessment Training Complete Cohort 2 B1 Integrated Healthcare Participants	0	02/01/19	02/01/19	60	
120 Core Standardized Assessment Go-Live(s) Cohort 2 B1 Integrated Healthcare Participants	0	04/26/19	04/26/19	61	
121 Closed Loop Referral Tool: Training	1d	02/21/19	02/21/19	74	
122 Closed Loop Referral Tool: Go-Live(s)	1d	04/04/19	04/04/19	75	
123 January - December 2020	262d	01/01/20	12/31/20		
124 Progress Assessment: Collect/Evaluate feedback ALL TOOLS	262d	01/01/20	12/31/20		
125 Evaluation Metrics Reporting (Data - per approved metrics)	936d	07/01/17	01/29/21		14%
126 On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/30/18		100%
127 prepare evaluation plan measures	152d	07/01/17	01/29/18		100%
128 submit	1d	01/30/18	01/30/18		100%
129 On-going data reporting for period ending 06/29/2018	152d	01/01/18	07/31/18		
130 prepare evaluation plan measures	151d	01/01/18	07/30/18		
131 submit	1d	07/31/18	07/31/18		

Attachment_A2.3

	Task Name	Duration	Start	Finish	Predecessors	% Complete
132	<input type="checkbox"/> On-going data reporting for period ending 12/31/2018	155d	07/01/18	01/31/19		
133	prepare evaluation plan measures	154d	07/01/18	01/30/19		
134	submit	1d	01/31/19	01/31/19		
135	<input type="checkbox"/> On-going data reporting for period ending 06/29/2019	152d	01/01/19	07/31/19		
136	prepare evaluation plan measures	151d	01/01/19	07/30/19		
137	submit	1d	07/31/19	07/31/19		
138	<input type="checkbox"/> On-going data reporting for period ending 12/31/2019	155d	07/01/19	01/31/20		
139	prepare evaluation plan measures	154d	07/01/19	01/30/20		
140	submit	1d	01/31/20	01/31/20		
141	<input type="checkbox"/> On-going data reporting for period ending 06/29/2020	153d	01/01/20	07/31/20		
142	prepare evaluation plan measures	152d	01/01/20	07/30/20		
143	submit	1d	07/31/20	07/31/20		
144	<input type="checkbox"/> On-going data reporting for period ending 12/31/2020	153d	07/01/20	01/29/21		
145	prepare evaluation plan measures	152d	07/01/20	01/28/21		
146	submit	1d	01/29/21	01/29/21		

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 to complement the project plan or provide further explanation.

The Coordinated Care Practice must include:

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

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

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

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

Progress Narrative

As outlined in our July 2017 Semi Annual Report (SAR), Network4Health contracted with the University of New Hampshire's Institute for Health Policy and Practice/ New Hampshire Citizens Health Initiative (NH CHI) group to utilize the Maine Site Self-Assessment (SSA) Evaluation Tool from the Maine Health Access Foundation Integration Initiative, providing a standardized assessment and identification of partners to meet coordinated care and integrated care requirements.

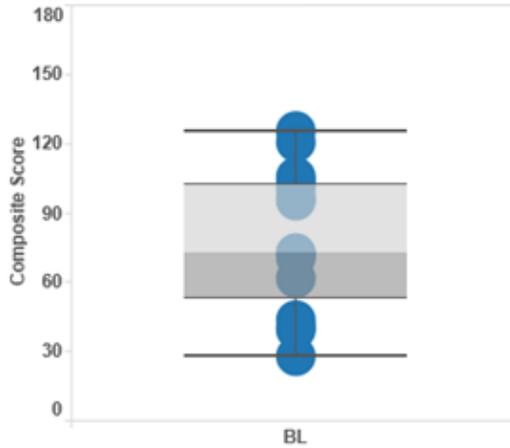
During the month of October 2017, the Network4Health primary care and behavioral health practices listed below completed the SSA survey and submitted their results to NH CHI.

No.	Organization Type	Organization / Practice Name
1	Primary Care	Catholic Medical Center - Healthcare for the Homeless (FQHC)

2	Primary Care	Catholic Medical Center - Behavioral Health Services
3	Primary Care	Catholic Medical Center - Family Health & Wellness Center at Bedford
4	Primary Care	Catholic Medical Center - Willowbend Family Practice
5	Primary Care	Catholic Medical Center - Amoskeag Family Practice
6	Primary Care	Catholic Medical Center - Hooksett Internal Medicine
7	Primary Care	Dartmouth-Hitchcock Manchester Adult Practice
8	Primary Care	Dartmouth-Hitchcock Bedford Adult Practice
9	Primary Care	Dartmouth-Hitchcock Bedford/Manchester Pediatric Practice
10	Primary Care	Elliot Health System - Elliot Family Medicine at Hooksett
11	Primary Care	Elliot Health System - Elliot Pediatrics and Primary Care at Riverside
12	Primary Care and Behavioral Health	Manchester Community Health Center (FQHC)
13	Behavioral Health	Mental Health Center of Greater Manchester (CMHC)
14	Behavioral Health	Center for Life Management
15	Behavioral Health	Child & Family Services
16	Behavioral Health	Families in Transition - Family Willows Treatment Center

Each practice received their individual SSA results in late November 2017 and on November 29, 2017, Network4Health and the practice facilitation team from NH CHI presented an overview of Network4Health's regional integration status to representatives of all practice sites and the larger Network4Health Integrated Care Advisory Board. The average SSA score for Network4Health's cohort 1 practices was 79 out of 180 points, translating to an average SAMHSA Integration Level III, per NH CHI's below crosswalk. Network4Health practices assessed their currently levels of integration between SAMHSA levels of integration II and IV.

Composite Score Distribution



Composite Scores by Practice

Practice	SSA No.
4-115	126
4-110	121
4-109	106
4-101	104
4-104	101
4-103	97
4-112	96
4-106	73
4-107	73
4-105	71
4-102	62
4-117	44
4-113	41
4-114	40
4-116	28

SAMHSA/SSA Crosswalk

SAMHSA Six Levels of Integration									
COORDINATED CARE		CO-LOCATED CARE		INTEGRATED CARE					
I	II	III	IV	V	VI				
Minimal Coordinated Care, Silos	Basic Collaboration at a Distance	Basic Onsite Collaboration	Close Collaboration On Site with Some Systems Collaboration	Close Collaboration Approaching a Fully Integrated Practice	Fully Collaboration Merge Transformed Integrated Practice				
Separate systems Separate culture Limited communication	Separate systems Separate culture Communication mostly written	Separate systems Separate culture Same facilities Occasional face-to-face meetings General role appreciation Communication occasionally face-to-face	Some shared systems Face-to-face consultation Coordinated treatment plans Basic appreciation of each other's role and cultures Collaborative routines difficult; time and operation barriers Influence sharing	Shared systems and facilities Consumers and providers have same expectations In-depth appreciation of roles and culture Collaborative routines Conscious influence	Single transformed practice, treats the whole patient				
MeHAF Site Self-Assessment Score Levels									
1	2	3	4	5	6	7	8	9	10
INTEGRATED SERVICES AND PATIENT AND FAMILY-CENTEREDNESS and PRACTICE/ORGANIZATION DOMAIN TOTAL									
0-18	19-46		47-82		83-126		127-162		163-180

In late December, the Network4Health B1 administrative team disseminated an Integration Enhancement Plan Project Development Overview Document (Attachment_B1.2a) to support our partner organizations understanding of required components of the B1 Integrated Healthcare Project. The document also provides teams with an internal planning tool to prepare for development of their Integration Enhancement Plan and outlines Network4Health’s anticipated process for review and approval of submitted plans.

Since our July 2017 SAR submission, Easterseals NH’s Farnum Center, Families in Transition, Center For Life Management and CMC’s Healthcare for the Homeless practices asked to delay participation and be included with our cohort 2 integration group due to other significant project work, staff turnover or a lack of internal capacity to either begin the Site Self-Assessment (SSA) process or proceed with the development of an Integration Enhancement Project. Serenity Place had also asked to delay participation to cohort 2. *As EOHHS is aware, Serenity Place was put into receivership in December 2017 by the NH Attorney General and as of the end of December; all Network4Health project work with Serenity Place was put on hold.* Additionally, due to limited staffing and small Medicaid billable work within the Network4Health geographic region, it was agreed that Child & Family Services (CFS) will be

removed from our list of practices working to attain Coordinated Care practice designation (Section B-11 in the July 2017 SAR). CFS works throughout the state of New Hampshire and expressed some concern regarding the multiple implementation paths across IDNs. The Network4Health administrative team is working to include CFS as a community support and referral partner within other Integration Enhancement Plan projects.

Of the practices who completed the Site Self-Assessment (SSA) Survey, the practices listed below have confirmed readiness to move forward with the first wave or “cohort 1” of the Network4Health Integration Enhancement Plans and will be submitting plans to be approved for initial funding in March 2018 with implementation beginning in April 2018¹.

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)

Except for one participating organization, all cohort 1 participants have indicated the need for significant practice facilitation to support the development and implementation of their Integration Enhancement Plan. The Network4Health administrative team worked throughout the July to December time period to recruit and hire our new Integrated Healthcare Clinical Director, [REDACTED] to provide practices with an experienced integrated healthcare resource for our region. [REDACTED] began her role with

¹ This reflects a slight delay in the the implementation start date for our cohort 1 participants from January 23, 2018 to April 2018.

Network4Health on January 2, 2018. Additionally, the team has been working since August on a contract with NH CHI to provide practice level facilitation resources to our integrated care practices, above and beyond implementation of the Site Self-Assessment Surveys. Similar to challenges faced by our HIT team, the contracting process has been lengthy due to clauses in the Administrative Lead contract that Catholic Medical Center signed with the state for the 1115 waiver program that must be passed down to all sub-contractors. The contract was signed by the University of New Hampshire on behalf of the NH CHI in late January and is anticipated to be fully executed by the end of January 2018. With the support of our new Integrated Care Clinical Director and the practice facilitation team at NH CHI, we feel confident we can support our cohort 1 partners to meet our new milestones.

Based on our experience with the first cohort of participants, Network4Health has also updated its project schedule to initiate work with cohort 2 in the below timeframe.

Cohort 2 Engagement Timeline	
Confirm Intent to Participate in Cohort 2	January and February 2018
Site Self-Assessment Survey	March 2018
Practice level Integration Enhancement Plan Introductions	April 2018
Provide E-Mail Confirmation of Intent to Submit	May 9, 2018
Cohort 2 Integration Enhancement Plan Submission Deadline	Wednesday 5/30/18
Cohort 2 Integration Enhancement Plan - Network4Health Administrative Review	5/31/18 – 6/11/18
Advisory Board Funding Review/Approval	Tuesday 6/12/18
Cohort 2 - Integration Enhancement Plan Implementation Start	July 2018

In parallel to our Site Self-Assessment efforts, Network4Health launched a bi-weekly Comprehensive Core Standardized Assessment (CCSA) Workgroup in October 2017. The goal of the workgroup was to identify a recommended set of evidence-based screening questions for each required CCSA domain and identify responses that identify vulnerable or “at risk” patients. The workgroup recognizes that not all partners will transition existing screening questions that meet the intent of a given CCSA domain, but the Network4Health Recommended CCSA will reflect what regional leaders feel are gold-standard and feasible screening questions for adoption by partner organizations when feasible. The CCSA 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
- Manchester Community Health Center
- Mental Health Center of Greater Manchester

The CCSA workgroup will be finalizing their CCSA recommendations in January 2018. The workgroup will then transition to additional integration topics as a weekly Integrated Care Workgroup to help support the development of cohort 1 Integration Enhancement Plans. Meetings will be facilitated by the Network4Health Integrated Care Clinical Director and HIT Director, with participation from our NH CHI practice facilitators. Topics will include:

- Referrals/DIRECT Secure Messaging Workflows
- Workforce enhancement opportunities in your Integration Enhancement Plans
- Existing Cohort 1 Care Plan Workflows
 - o Implementation of Case Reviews/Case Conferences: Patient Identification, Workflow, Patient Consent
- Shared Care Plan and Collective Medical Technologies functionality

In addition to our CCSA work, Network4Health Integrated Care Project representatives and our HIT Director participated in the Shared Care Plan Task Force sessions hosted by IDN 1. The Network4Health team supports the findings of the Task Force (Shared Care Plan Task Force Recommendations to IDN Leads 16 Nov 2017)(Attachment_B1.2b) and will be further evaluating the implementation feasibility with our cohort 1 partners through our Integrated Care Workgroup beginning in January 2018.

Updated work plans for our Coordinated Care partners and Integrated Care partners are included as Attachment_B1.2c and Attachment_B1.2d, 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.

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 37 practices by 12/31/18	9		
The number of participating partners who acquire the Event Notification System (ENS)	17 of 37 practices by 12/31/18	1		

Performance Measure Name	Target	Progress Toward Target		
The number of participating partners who acquire the Shared Care Plan (SCP)	17 of 37 practices By 12/31/18	0		
The number of participating partners who implement and receive training for DIRECT Secure Messaging	17 of 37 practices by 12/31/18	0		
The number of participating partners who implement and receive training for the Event Notification System (ENS)	17 of 37 practices by 12/31/18	0		
The number of participating partners who implement and receive training for the Shared Care Plan (SCP)	17 of 37 practices By 12/31/19	0		
The number of participating partners who contribute to DIRECT Secure Messaging	17 of 37 practices by 12/31/18	0		
The number of participating partners who contribute to Event Notification System (ENS)	10 of 37 practices by 12/31/18	1		
The number of participating partners who contribute to a Shared Care Plan (SCP)	10 of 37 practices By 12/31/19	0		
The number of participating partners who use DIRECT Secure Messaging	10 of 37 practices by 12/31/19	0		
The number of participating partners who use an Event Notification System (ENS)	10 of 37 practices by 12/31/19	0		
The number of participating partners who use a Shared Care Plan (SCP)	5 of 37 practices By 12/31/19	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 Integrated Care Clinical Director was recruited and hired prior to December 31, 2017. She officially started work at Network4Health on January 2, 2018. Network4Health has contracted with NH CHI to provide practice facilitation for all B1 Integrated Care implementation teams rather than hiring FTEs. Through the contract with NH CHI, Network4Health is able to provide consistent support to our integrated care participants and when needed draw from the expertise of the larger team of consultants at NH CHI.

Depending on the outcomes of the Integration Enhancement Plans, additional workforce needs may be identified other than those listed below. The need for Community Health Workers provided below is an estimate and is dependent on participant defined Integration Enhancement Plans.

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		
Innovation Consultant/Practice Facilitator	Recruiting up to 2	0	0		
Community Health Workers	Recruiting up to 10	0	0		

B1-5. IDN Integrated Healthcare: Budget

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

The following budget was submitted as part of the Network4Health Semi Annual Report dated October 3, 2017.

B1 INTEGRATED HEALTHCARE TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
B1: Revenue (New)	\$ 2,032,020	\$2,032,020	\$3,578,400	\$4,294,080
B1: Revenue (Rollover)		\$1,760,812	\$753	\$146
Total Revenue	\$2,032,020	\$3,792,832	\$3,579,153	\$4,294,226
Salaries (benefits & transportation included) Annual 3% increase reflected Included: 1 FT Integrated Healthcare Clinical Director	\$67,500	\$137,025	\$141,135	\$145,369
Technology (Laptops, phones, software)	\$3,000	\$3,000	\$3,000	\$3,000
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Baseline Assessment for 40 practices. Includes six month follow up assessments.	\$5,600	\$5,600	\$3,750	\$3,750
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Integration Enhancement Project plan development for up to 40 practices.	\$11,570	\$34,710		

B1 INTEGRATED HEALTHCARE TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Integration coaching for up to 40 practices	\$15,538	\$ 419,744	\$316,402	\$327,792
Practice level Integrated Healthcare Enhancement Project plan funding which include financial support to employ up to 10 CHW/Patient Navigators.	\$168,000	\$ 3,192,000	\$3,114,720	\$3,814,080
Subtotal	\$271,208	\$3,792,079	\$3,579,007	\$4,293,991
Variation to Budget (Transfer Funds to Subsequent Year)	\$1,760,812	\$753	\$146	\$235

At the time the first installment of CY2017 funding was distributed, it was noted that the total revenue provided for all project budgets was slightly increased over expected. Network4Health had anticipated that the State would be distributing \$26,500,000 in available funding for CY 2017. However, the State distributed funding based on \$27,000,000 in available funding, impacting 2017 and the following 3 calendar years. We have adjusted revenue projections based on the revised distribution formula. Subsequently, revisions have been made to anticipated CY 18, 19, and 20 budgets as reflected below:

B1 INTEGRATED HEALTHCARE TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual Expenses Posted	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
B1: Revenue (New)	\$2,070,106	\$2,070,106	\$3,450,177	\$4,293,553
B1: Revenue (Rollover)		\$2,067,306	\$248,149	\$33,707
Total Revenue	\$2,070,106	\$4,137,412	\$3,698,326	\$4,327,260
Salaries (benefits & transportation included)				
		\$159,525	\$163,635	\$167,869
Technology (Laptops, phones, software)		\$4,000	\$4,000	\$4,000
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Baseline Assessment for 40 practices. Includes six month follow up assessments.	\$2,800	\$6,534	\$4,683	\$4,683
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Integration Enhancement Project plan development for up to 40 practices.		\$46,280		

B1 INTEGRATED HEALTHCARE TRANSFORMATION FUNDS	CY 2017 (Yr2) Actual Expenses Posted	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
UNH Law Institute on Health Policy and Practice/Citizen's Health Initiative Integration coaching for up to 40 practices		\$424,924	\$321,581	\$332,971
Practice level Integrated Healthcare Enhancement Project plan funding which include financial support to employ up to 10 CHW/Patient Navigators.		\$3,241,100	\$3,163,820	\$3,811,180
Occupancy Offset		\$ 6,900	\$6,900	\$6,900
Subtotal	\$2,800	\$3,889,263	\$3,664,619	\$4,327,603
Variation to Budget (Transfer Funds to Subsequent Year)	\$2,067,306	\$248,149	\$33,707	\$(343)

The CY 2017 actual expense of \$2,800 was for the initial UNH/CHI initial organizational baseline assessments. All expense items related to the UNH Law Institute Integration Coaching have been reduced due to final contracting negotiations on the scope of assessments and coaching for the duration of the waiver period.

CY 2017 planned expenses were developed assuming a full six months of operations. Recruitment for the Program Director began in July with the position being filled full time beginning January 2, 2018. This slowed our ability to move forward with developing integration enhancement plans with organizations completing the UNH/CHI assessments. Network4Health anticipates that all planned expenses for CY2017 will be incurred in years 2018 – 2020 in the expense categories originally appearing in the budget and have been reallocated. A new expense line has been added for CY 2018, 2019 and 2020 in the amount of \$6,900 annually.

The CY 2018-20 expense items related to the UNH Law Institute have been reduced due to final contracting negotiations on the scope of assessments and coaching for the duration of the waiver period. The available funding for Integrated Healthcare Enhancement project plan has been increased in CY 2018 from \$3,192,000 to \$3,343,00 and decreased in CY 2019 from \$3,114,720 to \$3,063,375 and in CY 2020 from \$3,814,480 to \$3,840,900.

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

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

The key organizations that are working towards being coordinated care entities or integrated care entities under the SAMHSA Framework and the DSRIP STCs; each of these organizations have agreed to increase integration in their organization. These organizations have agreed to develop and implement Integration Enhancement Plans (IEPs) in order to meet the requirements of a coordinated care or an integrated care practice in either cohort 1 or cohort 2 of 2018 for a majority of their practices. All participating primary care and behavioral health organizations are listed below.

Organization/Provider	Agreement Executed (Y/N)
Catholic Medical Center (PCP/BH) Healthcare for the Homeless CMC Behavioral Health Bedford Center Internal Medicine and Pediatrics (New name. Form name: Family Health and Wellness Center at Bedford) Highlander Way Internal Medicine Hooksett Internal Medicine Willowbend Family Practice Family Physicians of Manchester Goffstown Family Practice Granite State Internal Medicine Highlander Way Internal Medicine Lakeview Internal Medicine Queen City Medical Associates Webster Street Internal Medicine	Y
Center for Life Management	Y
Dartmouth-Hitchcock (Manchester and Bedford)	Y
Easterseals NH, Farnum Center	Y
Elliot Health System (PCP/BH) Elliot Primary Care at Bedford Pediatric Health Associates, Bedford Doctors Park Pediatrics, Manchester Pediatric Health Associates, Manchester Elliot Behavioral Health Services Elliot Pediatrics and Primary Care at Riverside Elliot Family Medicine, Hooksett Dr. Kenneth D. Thomas Elliot Family Medicine at Goffstown Elliot Family Medicine at Windham Elliot Pediatrics at Windham Elliot Primary Care at Londonderry Elliott Internal Medicine at Londonderry Senior Health Primary Care Briarwood Primary Care Derryfield Medical Group	Y
Families in Transition, Family Willows Treatment Center	Y

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

**Participation on hold as organization is under-receivership*

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

If all IDN Governance sign-offs were YES in the July 2017 submission and there are no changes, then a resubmission of this section is not required. If any sign-offs were NO, then resubmission of this information is required with the signatures noted as received.

Network4Health indicated all governance sign-offs as part of the July 2017 submission.

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

B1-8a

Network4Health launched a bi-weekly Comprehensive Core Standardized Assessment (CCSA) Workgroup in October 2017. The goal of the workgroup was to identify a recommended set of evidence-based screening questions for each required CCSA domain and identify responses that identify vulnerable or “at risk” patients. *The workgroup reviewed all CCSA domain areas and available evidence based tools for each. Through this process, participating organizations reviewed their current screenings and were asked to begin internal discussions around their CCSA implementation plans to identify modification of current workflows and screening tools to align with all domains of the CCSA during the intake, rooming and treatment process. Organizations were asked to consider aligning to the recommended screening questions created by the workgroup in hopes of consistency for patients within the Network4Health region.* The workgroup recognizes that not all partners will transition all existing screening questions that meet the intent of a given CCSA domain, but the Network4Health Recommended CCSA will reflect what regional leaders feel are gold-standard and feasible screening questions for adoption by partner organizations when feasible. The CCSA 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

- Manchester Community Health Center
- Mental Health Center of Greater Manchester

Attachment_B1.8a.1 is the draft Network4Health CCSA that is under review for approval by the Network4Health CCSA workgroup in January 2018. Network4Health partners will provide documentation of their CCSA implementation as part of their Integration Enhancement Project. The first Network4Health Integration Projects are anticipated to begin implementation in April 2018.

Network4Health provides further detail on organizational progress on use of screenings under this domain as Attachment_B1.8a.2. Within the table, a “yes” indicates that the organization is currently screening in this domain using current workflows; and a “progress” indicates that an organization has made progress during the reporting period. We do not have detailed information on Easter Seals/Farnum as during this reporting period they were in the process of designing and implementing a new electronic health record, and were not yet able to provide specific detail about their screenings. However, they have reported to Network4Health that they are in compliance with various governmental, quality and payer requirements regarding screenings. The plan is to gather detailed information during their Cohort 2 Integrated Enhancement Plan participation, which will be submitted by May 30, 2018.

B1-8b

Network4Health partners will identify their multi-disciplinary core team members as part of their Integration Enhancement Project. *Throughout this reporting period, Network4Health staff educated the 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 All-Partners quarterly meetings. Further discussion about current state, gaps and future state of multi-disciplinary core teams occurred during individual partner meetings. Partners have multi-disciplinary teams at various stages along the maturity model. 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 have limited staff of PCP’s, nursing, and administrative staff with limited care coordination, and opportunities to create stronger teams. Network4Health worked with its partners during this reporting period to better define and identify opportunities to strengthen the multi-disciplinary core teams. Further work to evolve multi-disciplinary teams will be outline in Integration Enhancement Plans (IEPs). The first Network4Health Integration Projects are anticipated to begin implementation in April 2018.*

Organization/Provider	Multi-Disciplinary Team Identified	Team List
<i>Catholic Medical Center - Amoskeag Family Practice</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative</i>

		<i>PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - CMC Behavioral Health</i>	Yes	<i>Psychiatrist, APRN, LICSW, LCMHC, MLADC, MA, Dept Coordinators, Director</i>
<i>Catholic Medical Center - Hooksett Internal Medicine</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Willowbend Family Practice</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Formerly: Family Health & Wellness Center at Bedford)</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Family Physicians of Manchester</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center -Goffstown Family Practice</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Granite State Internal Medicine</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative</i>

		<i>PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Highlander Way Internal Medicine</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Lakeview Internal Medicine</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Queen City Medical Associates</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Webster Street Internal Medicine</i>	Yes	<i>Triage Nurse RN Clinical Coordinator Medical Assistant RN Care coordinator Office Coordinator Patient Service Representative PPA Social Worker (outside of practice)</i>
<i>Catholic Medical Center - Healthcare for the Homeless – FIT Clinic</i>	Yes	<i>1 MD or APRN 1 Program Assistant 1 RN Care Coordinator 1 BH provider on call (either the MLADC, LMHW or SW) Psychiatric APRN (shared resource)</i>
<i>Catholic Medical Center - Healthcare for the Homeless – New Horizons Clinic</i>	Yes	<i>Primary Care MD or APRN RN Care Coordinator Program Assistant Outreach Enrollment Specialist BH provider (MLADC, LMHW or SW) Psychiatric APRN (shared resource)</i>
<i>Center for Life Management</i>	Yes	<u><i>Community Support Program / "Eligible" Adults</i></u>

		<ul style="list-style-type: none"> • <i>Medical provider (MD or APRN) and RN</i> • <i>Clinician (provided by LICSW, LCMHC, MLADC, MSW. MA, or MS)</i> • <i>Case Manager</i> • <i>Functional Support service provider (FSS)</i> • <i>Supported Employment Specialist (SEP)</i> • <i>Admin Support</i> • <i>Benefits Specialist</i> • <i>Homeless Specialist</i> <p><i>ACT / Assertive Community Treatment:</i></p> <ul style="list-style-type: none"> • <i>Medical provider (MD or APRN) and RN</i> • <i>Clinician (provided by LICSW, LCMHC, MLADC, MSW. MA, or MS)</i> • <i>Case Manager</i> • <i>Functional Support Service provider (FSS)</i> • <i>Supported Employment Specialist (SEP)</i> • <i>Admin Support</i> • <i>Benefits Specialist</i> • <i>Homeless Specialist</i> • <i>Peer Support Specialist</i> <p><u><i>Non-Eligible Adults being served through CLM's Adult Outpatient Department (AOP)</i></u></p> <ul style="list-style-type: none"> • <i>Clinician (LICSW, LCMHC, MLADC)</i> • <i>Limited access to med providers</i> • <i>Access to emergency services</i> • <i>Admin support</i> <p><u><i>Children, Youth, and Family Department</i></u></p> <ul style="list-style-type: none"> • <i>Medical Provider (MD and/or APRN) and RN</i> • <i>Clinician (LICSW, LCMHC, MLADC, LMFT, MSW. MA, or MS)</i> • <i>Case Manager (if eligible)</i> • <i>Functional Support Service</i>
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		<i>Provider (if eligible)</i> <ul style="list-style-type: none"> • <i>Admin support</i>
<i>Dartmouth-Hitchcock Bedford/Manchester Adult</i>	<i>Yes</i>	<i>Primary Care Provider</i> <i>Associate Provider</i> <i>RN</i> <i>Medical Assistant</i> <i>Secretary</i> <i>Care Coordinator</i> <i>Family Support Specialist</i> <i>Diabetes Educator</i> <i>Coumadin RN</i> <i>Medication Assistance Program Manager</i>
<i>Dartmouth-Hitchcock Bedford/Manchester Pediatric</i>	<i>Yes</i>	<i>Primary Care Provider</i> <i>Associate Provider</i> <i>RN</i> <i>Medical Assistant</i> <i>Secretary</i> <i>Care Coordinator</i> <i>Family Support Specialist</i> <i>Manager</i> <i>Psychiatrist</i> <i>Child Life Specialist</i>
<i>Easterseals NH/ Farnum Center</i>	<i>No</i>	<i>Multi-disciplinary team will be identified as part of their cohort 2 IEP (April/May 2018)</i>
<i>Elliot Health System - Elliot Primary Care at Bedford</i>	<i>Yes</i>	<i>Primary Care Providers</i> <i>Nurses</i> <i>Medical assistants</i> <i>Patient services representatives</i>
<i>Elliot Health System - Pediatric Health Associates, Bedford</i>	<i>Yes</i>	<i>Primary Care Providers</i> <i>Nurses</i> <i>Medical assistants</i> <i>Patient services representatives</i>
<i>Elliot Health System - Doctors Park Pediatrics, Manchester</i>	<i>Yes</i>	<i>Primary Care Providers</i> <i>Nurses</i> <i>Medical assistants</i> <i>Patient services representatives</i>
<i>Elliot Health System - Pediatric Health Associates, Manchester</i>	<i>Yes</i>	<i>Primary Care Providers</i> <i>Nurses</i> <i>Medical assistants</i> <i>Patient services representatives</i>
<i>Elliot Health System - Elliot Behavioral Health</i>	<i>Yes</i>	<i>Primary Care Providers</i>

<i>Services</i>		<i>Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Elliot Pediatrics and Primary Care at Riverside</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Elliot Family Medicine at Hooksett</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Dr. Kenneth D. Thomas</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Elliot Family Medicine at Goffstown</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Elliot Family Medicine at Windham</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Elliot Pediatrics at Windham</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Elliot Primary Care at Londonderry</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Elliott Internal Medicine at Londonderry</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Senior Health Primary Care</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Elliot Health System - Briarwood Primary Care</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>

<i>Elliot Health System - Derryfield Medical Group</i>	<i>Yes</i>	<i>Primary Care Providers Nurses Medical assistants Patient services representatives</i>
<i>Families in Transition / Family Willows Treatment Center</i>	<i>No</i>	<i>Multi-disciplinary team will be identified as part of their cohort 2 IEP (April/May 2018)</i>
<i>Manchester Community Health Center – Child Health Services</i>	<i>Yes</i>	<i>Providers, nurses, Medical Assistant’s, Community Health Workers, Behavioral Health Consultants, Case Managers</i>
<i>Manchester Community Health Center – Hollis Street, East Side, West Side Neighborhood Health Center</i>	<i>Yes</i>	<i>All teams have providers, nurses, Medical Assistants, but the Behavioral Health Consultant’s and Case Managers are shared across the three sites, with no Community Health Workers working exclusively with these sites</i>
<i>Mental Health Center of Greater Manchester</i>	<i>Yes</i>	<i>Adult Level 2-Master’s level Clinicians(LICSW and LCMHC), Psychiatrist, APRN, Team Coordinators, Supported Employment Specialist, MLADC</i> <i>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</i> <i>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</i> <i>Kids Level 2-Master’s Level Clinicians, Psychiatrist or APRN, Team Coordinator, Bachelor Level CM</i> <i>Kids Level 3-Master’s Level Clinicians, Psychiatrist or APRN, Team Coordinator, Bachelor Level CM</i> <i>Kids Level 4-Master’s Level Clinicians, Psychiatrist, Team Coordinator</i>
<i>Serenity Place*</i>	<i>No</i>	<i>Serenity Place has been placed in receivership</i>

B1-8c

Network4Health will provide training to key organizations and their multi-disciplinary core team service providers on a variety of topics, as identified as needed as part of the IEP including competencies, and at a minimum:

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

The training plan, included as Attachment_B1.8c, provides a detailed look at training that will be required of providers for participating practices. *Network4Health is working 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 organizations Integrated Enhancement Plan across both their multi-disciplinary core teams and non-clinical staff.*

Required Courses

Network4Health participants have indicated a strong desire to attend Cherokee Training sessions. Network4Health is in the process of coordinating Cherokee Trainings in the second half of 2018 that would cover both the Behavioral Health 101 and Integration in Practice requirements for a participating practice. For practices choosing not to participate in the Cherokee Trainings or for which not all team members can attend, Network4Health is making available quarterly Mental Health First Aid offerings to meet the Behavioral Health 101 requirement or schedule a custom onsite session for the Behavioral Health and Integration in practice requirement. Network4Health is offering the first Mental Health First Aid course on April 11-12, 2018. We intend to offer these quarterly. Network4Health is working with a trainer at Manchester Community Health Center to contract for a custom course to be delivered onsite with participating organizations. 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.

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 in Q1 or Q2 2018. 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.sbirtraining.com/SBIRT-Core>.

B1-8d

Network4Health will provide training for staff that is not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management. The Training Plan, *included as Attachment_B1.8c*, also includes trainings that will be provided to non-clinical staff. The Network4Health Integrated Healthcare project will provide additional practice or organization level training information in alignment with practice level Integration Enhancement Plans.

Network4Health is working 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 organizations Integrated Enhancement Plan across both their multi-disciplinary core teams and non-clinical staff.

Required Courses

Network4Health participants have indicated a strong desire to attend Cherokee Training sessions. Network4Health is in the process of coordinating Cherokee Trainings in the second half of 2018 that would cover both the Behavioral Health 101 and Integration in Practice requirements for a participating practice. For practices choosing not to participate in the Cherokee Trainings or for which not all team members can attend, Network4Health is making available quarterly Mental Health First Aid offerings to meet the Behavioral Health 101 requirement or schedule a custom onsite session for the Behavioral Health and Integration in practice requirement. Network4Health is offering the first Mental Health First Aid course on April 11-12, 2018. We intend to offer these quarterly. Network4Health is working with a trainer at Manchester Community Health Center to contract for a custom course to be delivered onsite with participating organizations. 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.

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 in Q1 or Q2 2018. Organizations will be expected to provide training within 2018.

B1-8e

Network4Health partners will identify a schedule for core team case conferences as part of their Integration Enhancement Project, *which are scheduled to begin implementation in April 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 Practices*
- *Elliot Primary Care*
- *Mental Health Center of Greater Manchester*
- *Center for Life Management*

During this time period, Network4Health made progress by providing 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. Plans to develop comprehensive approaches addressing barriers, workflows and protocols at both the IDN and organizational levels are underway and scheduled to be completed by June 2018.

B1-8f

Network4Health's HIT Director met with participating Network4Health B1 partner organizations during the reporting period to discuss the status of DIRECT Secure Messaging and other HIT tools within their organization. Nine organizations confirmed they have DIRECT secure messaging implemented in conjunction with their EHR. In alignment with Network4Health's A2 HIT plan, any partner without DIRECT messaging implemented will include implementation of the selected Network4Health DIRECT messaging vendor in their Integration Enhancement Plan. In addition, Network4Health identified multiple gaps in the use of this technology across entities, consistency of use and the sharing and maintenance of direct addresses. Network4Health will utilize the bi-monthly Integrated Care Workgroup, attended by all participating organizations to support the continued education on secure messaging use and recommend areas of increased usage across organizations. The first Network4Health Integration Projects are anticipated to begin implementation in April 2018.

B1-8g

The bi-weekly Integrated Care workgroup (formerly named the CCSA workgroup) and individual partner meetings were utilized to discuss the status and requirements around Closed Loop Referrals for the project. Some partner organizations, such as Catholic Medical Center and Manchester Community Health Center have indicated extensive documented protocols for closed loop referrals within their organizations. Other partners acknowledged more adhoc work around closed loop referrals within their organization.

As outlined in the A2 HIT Plan, section A2-3, within Closed Loop Referral Support, Network4Health also presented the option for organizations to consider including the implementation of a Closed Loop Referral tool as part of the HIT component of their Integration Enhancement Plan. Network4Health partners will either provide existing and planned protocols as part of their Integration Enhancement Plan or indicate their desire to implement the selected Network4Health Closed Loop Referral system. The first Network4Health Integration Projects are anticipated to begin implementation in April 2018. This also aligns with Network4Health's Closed Loop Referral System RFP process targeted for final vendor selection in the first quarter of 2018. For those organizations selecting to implement the Closed Loop Referral Support tool, the A2 project plan outlines expectations of contract signatures, implementation and training all beginning in April 2018 through project completion by mid 2019. This timeline allows organizations to make progress on their closed loop referral workflows in support of the tool implementation.

B1-8h

Progress was made regarding workflows and protocols through current state assessment and through education and discussion at the bi-weekly Integrated Care Workgroup meetings (formerly named the CCSA workgroup) and the late November Integrated Care Advisory Board meeting around the expectations for documented protocols in organization’s Integration Enhancement Plan (plans due in February 2018). 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. Network4Health requested that each organization provide an evaluation of the community based organizations to which they will refer for the social determinant of health domains in the Comprehensive Core Standardized Assessment (CCSA) as part of their Integration Enhancement Plan to support the development of their CCSA workflows and protocols. This work began in December 2017.

Network4Health learned that many partners have documented workflows and protocols for the safe transitions from institutional settings back to primary care, behavioral health and social support service providers. These workflows and protocols will be reviewed, updated and submitted during implementation of Integration Enhancement Plans beginning in April 2018.

The Network4Health administrative team participated in cross-IDN discussions in late October and early November regarding Shared Care Planning and the associated privacy and consent concerns that will impact the current consent to confidentially share information that our partner organizations have in place. Partner organizations all indicated existing procedures to solicit patient consent to confidentially share information. These workflows and protocols will be reviewed, updated and submitted during implementation of Integration Enhancement Plans beginning in April 2018.

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
B1-2	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				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
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	<p>All of the following domains must be included in the CCSA:</p> <ul style="list-style-type: none"> • Demographic information • Physical health review • Substance use review • Housing assessment • Family and support services • Educational attainment • Employment or entitlement • Access to legal services • Suicide risk assessment • Functional status assessment • Universal screening using depression screening (PHQ 2 & 9) and • Universal screening using SBIRT 	<p>CCSAs (Submit all that are in use)</p> <p>Table listing all providers by domain indicating Y/N on progress for each process detail</p>				
	<p>For pediatric providers, the CCSA must also include:</p> <ul style="list-style-type: none"> • Validated 	Table listing all providers by domain indicating Y/N on				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	<p>developmental screening for all children, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits;</p> <ul style="list-style-type: none"> Developmental Screening using Bright Futures or other American Academy of Pediatrics recognized developmental 	progress for each process detail				
B1-8b	<p>List of multi-disciplinary core team members that includes, at minimum:</p> <ul style="list-style-type: none"> PCPs Behavioral health providers (including a psychiatrist) Assigned care managers or community health worker 	Table listing names of individuals or positions within each provider practice by core team				
B1-8c	<p>Multi-disciplinary core team training for service providers on topics that includes, at minimum:</p> <ul style="list-style-type: none"> Diabetes hyperglycemia Dyslipidemia Hypertension Mental health topics (multiple) SUD topics (multiple) 	<p>Training schedule and Table listing all provider practice sites and number of individuals by provider type to be trained, PCP or BH. Ongoing reporting shall indicate # of people trained in each practice by</p>				

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
		<p>provider type for each reporting period for each training.</p> <p>OR you may provide a list of names of all individual providers to be trained in each provider practice. Ongoing reporting would indicate Y/N for participating individuals on progress for each training</p>				
B1-8d	Training for staff not providing direct care that at minimum includes knowledge and beliefs about mental disorders that can aid in recognition and management	Training schedule and table listing all staff indicating progress on each process detail				
B1-8e	Monthly (or more frequent) core team case conferences on behalf of patients with significant behavioral health conditions or chronic conditions	Conference schedule and Table				
B1-8f	Secure messaging	Narrative				
B1-8g	Closed loop referrals	Narrative				

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

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

B1-9a Coordinated Care and Integrated Care Practice Designation:

In alignment with Network4Health's Integrated Care project plan, Manchester Community Health Center (MCHC) and Catholic Medical Center's Healthcare for the Homeless (HCH) practice completed the NH CHI Site Self-Assessment Survey (SSA). Both organizations have agreed to work towards Integrated Care practice designation and both organizations scored on the higher end of the IDN's participants on their SSA, indicating close on-site collaboration with some system collaboration. MCHC has created an internal workgroup to complete their Integration Enhancement Plan for cohort 1 funding in March 2018. *MCHC has been an instrumental partner in the Comprehensive Core Standardized Assessment (CCSA) and Integrated Care Workgroup. MCHC shared many of their current screenings and plans regarding the PRAPARE social determinants of health screenings for discussion and evaluation by the Network4Health workgroup. They further created an internal team to work on the alignment of their current workflows and screenings with the Network4Health recommended CCSA.*

Due to a significant transition in the leadership of Healthcare for the Homeless, they have moved to cohort 2. They will begin work on their Integration Enhancement Plan in April 2018, with implementation beginning in July 2018.

All other organizations will be working towards coordinated care practice designation and will be working in either cohort 1 or cohort 2 to develop their Integration Enhancement Plans (IEPs).

B1-9b

As previously reported, MCHC runs a fully implemented Medication Assisted Treatment (MAT) program. Healthcare for the Homeless has been actively planning implementation of their MAT program throughout the reporting cycle through existing grant funds. The funding source will expire in 2018 and Network4Health will provide support for the final development and implementation efforts for the Healthcare for the Homeless MAT program through their Integration Enhancement Plan. As previously note, Healthcare for the Homeless will be creating an Integration Enhancement Plan in cohort 2 beginning in April 2018, with implementation beginning in July 2018.

MCHC has also begun planning for implementation of the IMPACT model of depression care. MCHC plans to submit a request for funding support to Network4Health for the implementation of the IMPACT model through their Integration Enhancement Plan that will be submitted to Network4Health in February 2018. Included in their Integration Enhancement Plan will be a plan for training and rollout of the IMPACT model.

B1-9c

At Risk Patients

Network4Health practices 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, Attachment_B1.9c demonstrates Healthcare for the Homeless' already implemented risk identification tool. MCHC also already utilizes practice specific logic to identify at risk

patients utilizing their EMR. Through our Integrated Care Workgroup, Network4Health has agreed with participants the need to identify risk identification criteria for patients who will be proposed for Shared Care Planning using the Collective Medical Technologies (CMT) PreManage Community portal (in alignment with the rollout of CMT and shared care planning through each organizations Integration Enhancement Plan). The criteria will be used by each organization as a starting point for the identification of Medicaid patients within their practice for Share Care Planning. In additional to utilizing each practices EMR, Network4Health is discussing the 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.

Plan Care/ Monitor/Manage Patients Progress Towards Goals

Both MCHC and HCH utilize workflows within their EMRs to set goals and track progress towards meeting these goals. MCHC currently utilizes care plans for specific patient risk groups. MCHC 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.

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 above, 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 will either provide existing and planned protocols and their use in existing tools as part of their Integration Enhancement Project or indicate their desire to implement the selected Network4Health automated Closed Loop Referral system. The first Network4Health Integration Projects are anticipated to begin implementation in April 2018, with Healthcare for the Homeless beginning in July 2018 in our cohort 2 group. For those organizations selecting to implement the automated Closed Loop Referral Support tool, the A2 project plan outlines expectations of contract signatures, implementation and training all beginning in April 2018 through project completion by mid-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

B1-9d

Utilizing the Network4Health asset map created in the first half of 2017, Network4Health B1 project partners are now identifying which key community based social support partners will support them in the implementation of each domain of the Comprehensive Core Standardized Assessment. Through partner Integration Enhancement Plans, Network4Health will support the development of joint protocols or memorandums of understand, where needed. While this work is in development, ██████████ Continuum of Care Coordinator for Manchester with Makin' It Happen has made the Network4Health asset map information available under "Support Services" section of the NH Community Compass website. This provides additional access to both patients and our Network4Health partners. The website can be found at: <http://mih4u.org/communitycompass/>.

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

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

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
B1-9a	Coordinated Care Practice designation	Achievement of all of the requirements of a Coordinated Care Practice	Progress towards Coordinated Care Practice Designations				
B1-9b	Additional Integrated Practice designation requirements	Adoption of both of the following evidence-based interventions: <ul style="list-style-type: none"> • Medication-assisted treatment (MAT) • Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either through use of the IMPACT or other evidence-supported model 	Protocols (Submit all in use)				

Process Milestone Number	Section	Process Detail	Submission Format	Results (Met/Not Met)			
				6/30/17	12/31/17	6/30/18	12/31/18
• B1-9c		<ul style="list-style-type: none"> • Use of technology to identify, at minimum: • At risk patients • Plan care • Monitor/manage patient progress toward goals • Ensure closed loop referral 	<ul style="list-style-type: none"> • Table listing all providers indicating progress on each process detail 				
B1-9d		Documented work flows with community based social support service providers including, at minimum: <ul style="list-style-type: none"> • Joint service protocols • Communication channels 	Work flows (Submit all in use)				

B1-12. Project Scoring: IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

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

As indicated in our progress updates in B1.8 and B1.9 above, many Network4Health practice partners are currently performing or making progress towards the key process details required for Coordinated Care or Integrated Care practice designation under the DSRIP special terms and conditions. The number designated for 12/31/17 in below table reflects the number of practices making active progress towards designation.

Please note that the goal number for Coordinated Care Practice has been updated to 36, as Child & Family Services and Home Health & Hospice were both removed from our list of Coordinated Care Practices as the core services provided in our region are as a Community Social Support Agency, rather than a primary care or core behavioral health provider. We have also added Manchester Community Health Center on our list of Coordinated Care Practices as they will make progress on both Coordinated Care and Integrated Care designation requirements. Please note that Healthcare for the Homeless is always listed under Catholic Medical Center.

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

	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 - CMC Behavioral Health		Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)		
2	Catholic Medical Center - Bedford Center Internal Medicine and Pediatrics (New name. Form name: Family Health and		Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018		

	Wellness Center at Bedford)		<i>(Cohort 1)</i>		
3	Catholic Medical Center - Highlander Way Internal Medicine		<i>No progress.</i>		
4	Catholic Medical Center - Hooksett Internal Medicine		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)</i>		
5	Catholic Medical Center - Willowbend Family Practice		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)</i>		
6	Catholic Medical Center - Healthcare for the Homeless		<i>No progress. Dependent on IEP in Q3 2018 for Cohort 2</i>		
7	Catholic Medical Center - Amoskeag Family Practice		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)</i>		

8	Catholic Medical Center - Family Physicians of Manchester		<i>No progress.</i>		
9	Catholic Medical Center - Goffstown Family Practice		<i>No progress.</i>		
10	Catholic Medical Center - Granite State Internal Medicine		<i>No progress.</i>		
11	Catholic Medical Center - Lakeview Internal Medicine		<i>No progress.</i>		
12	Catholic Medical Center - Queen City Medical Associates		<i>No progress.</i>		
13	Catholic Medical Center - Webster Street Internal Medicine		<i>No progress.</i>		
14	Dartmouth-Hitchcock Manchester		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)</i>		
15	Dartmouth-Hitchcock Bedford		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q1</i>		

			2018 (Cohort 1)		
16	Elliot Health System - Elliot Family Medicine at Hooksett		Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)		
17	Elliot Health System - Elliot Pediatrics and Primary Care at Riverside		Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)		
18	Elliot Health System - Elliot Family Medicine at Goffstown		No progress.		
19	Elliot Health System - Elliot Primary Care at Bedford		No progress.		
20	Elliot Health System - Elliott Internal Medicine at Londonderry		No progress.		
21	Elliot Health System - Elliot Primary Care at Londonderry		No progress.		

22	Elliot Health System - Briarwood Primary Care		<i>No progress.</i>		
23	Elliot Health System - Derryfield Medical Group		<i>No progress.</i>		
24	Elliot Health System - Doctors Park Pediatrics		<i>No progress.</i>		
25	Elliot Health System - Dr. Kenneth D. Thomas		<i>No progress.</i>		
26	Elliot Health System - Pediatric Health Associates, Manchester		<i>No progress.</i>		
27	Elliot Health System - Senior Health Primary Care		<i>No progress.</i>		
28	Elliot Health System - Elliot Pediatrics at Windham		<i>No progress.</i>		
29	Elliot Health System - Elliot Family Medicine at Windham		<i>No progress.</i>		
30	Elliot Health System - Elliot Behavioral Health Services		<i>Progress made. Full scope of progress for 2018 to be identified in</i>		

			<i>IEP in Q1 2018 (Cohort 1)</i>		
31	Mental Health Center of Greater Manchester		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)</i>		
32	Center for Life Management		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q2 2018 (Cohort 2)</i>		
33	Serenity Place*		On hold		
34	Families in Transition / Family Willows Treatment Center		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q2 2018 (Cohort 2)</i>		
35	Easterseals NH/ Farnum Center		<i>Progress made. Full scope of progress for 2018 to be identified in IEP in Q2</i>		

			2018 (Cohort 2)		
35	Easterseals NH/ Farnum Center		Progress made. Full scope of progress for 2018 to be identified in IEP in Q2 2018 (Cohort 2)		
36	Manchester Community Health Center		Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)		
37	Child & Family Services		No progress.		

*Since Serenity Place has been put in receivership, we do not anticipate them continuing to participate in this project going forward.

Integrated Care Practice	List of providers identified to make progress toward Integrated Care Practice designation	12/31/17	6/30/18	12/31/18
Manchester Community Health Center		Progress made. Full scope of progress for 2018 to be identified in IEP in Q1 2018 (Cohort 1)		
Catholic Medical Center - Healthcare for the Homeless		No progress. Dependent on IEP in Q3 2018 for Cohort 2		



Integration Enhancement Plan

Project Development Overview

Integrated Healthcare Project (B1)

NEW HAMPSHIRE DELIVERY SYSTEM REFORM INCENTIVE PROGRAM

December 21, 2017

Contact information:



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Overview

Through the Integrated Healthcare Project, Network4Health (Region 4’s Integrated Delivery Network) looks to support primary care, mental health and substance use disorder organizations achieve “Coordinated Care” or “Integrated Care” designation by December 31, 2018 as outlined by the New Hampshire Delivery System Reform Incentive Program (DSRIP) (see Appendix A for DSRIP Integrated Healthcare Project Details).

Organizations are asked to assess their current level of integration of behavioral health and medical care, and make incremental improvements towards a more integrated model of healthcare delivery to help better address the full range of an individual’s needs across primary care, mental health, substance use disorder and social supports.

Purpose

This document outlines the needed components of an Integration Enhancement Plan to allow for the distribution of funds for Network4Health’s Integrated Healthcare Project. *Funds must be used to meet the goals of the DSRIP Integrated Healthcare demonstration project (see Appendix A) and are independent of current Medicaid patient reimbursement funds.*

Network4Health project funding supports practice transformation in the following New Hampshire towns. See [Appendix B](#) for additional IDN 4 geographic information.

IDN 4: Network4Health

Atkinson	Deerfield	Manchester
Auburn	Derry	New Boston
Bedford	Goffstown	Plaistow
Candia	Hampstead	Salem
Chester	Hooksett	Sandown
Danville	Londonderry	Windham

Participants

- Network4Health encourages multiple participating organizations to define collaborative projects within an *Integration Enhancement Plan*. All Integration Enhancement Plan participants must be members of Network4Health (See Appendix D) and have completed a certificate of authorization. If you wish to include a new member, please reach out to [REDACTED], Network4Health Executive Director, [REDACTED]
- Please identify a primary or lead agency for Integration Plans. **The lead agency will maintain fiduciary and reporting responsibilities.**
- Participating organizations should be categorized as:
 - Health and human service organizations (primary care, mental health, substance use disorder service providers)
 - Community-based organizations providing social or community support services

Evaluation Process

Network4Health will employ a system to evaluate each Integration Enhancement Plan proposal for funding and implementation readiness by our multi-stakeholder Project Advisory Board which, represents a broad array of Network4Health participants.

- **Initial Review:** The Network4Health Integrated Healthcare Administrative Leads will review the project for alignment with the DSRIP waiver project goals and requirements. Every effort will be made to include an independent reviewer in the initial review process.
- **Integrated Healthcare Project Advisory Board Approval:** The Integrated Healthcare Project Advisory Board will have the opportunity to review and approve the recommendation on scope, implementation readiness and proposed funding levels for the Integration Enhancement Plan.
- **Network4Health Steering Committee Approval:** Final funding approval must be received from the Steering Committee prior to fund disbursement.

Committee Name	Committee Composition	Evaluation Criteria
Integrated Healthcare Administrative Leads	<ul style="list-style-type: none"> • N4H Executive Director • B1 Project Co-Leads • N4H Integrated Healthcare Director • N4H Project Manager • N4H Systems Engineer 	<ul style="list-style-type: none"> • Does this proposal align with the scope of work advanced by Network4Health and the DSRIP Integrated Healthcare project? • Is there a contract on file? See “following the review process” below.
N4H Project Advisory Board	<ul style="list-style-type: none"> • Representatives of most Network4Health partner organizations • IDN Administrative Leads 	<ul style="list-style-type: none"> • Review all criteria and recommendations of Network4Health Administrative Leads. • Make every effort to ensure the proposals preclude biases and conflict of interests
N4H Steering Committee	<ul style="list-style-type: none"> • 12 voting members • IDN Administrative Leadership Team (non voting) 	<ul style="list-style-type: none"> • Aligns with program goals and project budget

Note: Any member of the N4H Project Advisory Board or Steering Committee whose organization is in consideration for funds must recuse him/herself from vote but can be part of the discussion (after making the conflict of interest known to the respective review body).

Following the review process, Network4Health Integrated Healthcare Administrative Leads will complete the following:

- Notify participants of plan approval and available funding levels
- Execute a Services Agreement, if not already in place, with the lead participant outlining the project scope and funding (in partnership with Legal and Finance)
 - Responsibilities for lead organizations may also include the following:
 - Regular meetings among specified project/pilot team members
 - Participation in project-specific Network4Health Learning Events to share learnings with regional teams working on the same project implementation or preparing to implement the same project

- Completion of the Integrated Health Site Self-Assessment Survey (SSA) provided in conjunction with the NH Citizen’s Health Initiative at 6-month intervals. Timing will be initiated by the Network4Health Integrated Healthcare Administrative Leaders
- Implementation of core technology systems to support care collaboration (note that technology subscription costs will be covered by the IDN for the duration of the waiver)
- Mentorship for those organizations also planning to implement the same project or expanding programs in their region
- Participation in quality reporting activities required of the 1115 waiver
- Additional responsibilities may be requested based on NH Delivery System Reform Incentive Program requirements from the NH Department of Health and Human Services. Participants will be asked to support any program requirements.

Funds must be used within the 12-month time period for which they are approved, or an extension must be requested by the last day of the month prior to the closing date.

Network4Health Integration Enhancement Plan

Please concisely answer the below questions within your Integration Plan. Please reach out to your assigned Integration Coach or the Integrated Healthcare Project Manager [REDACTED] with any questions. The Administrative Lead team will connect directly with the primary contact listed to coordinate any discussions during the review and funding approval process. The Network4Health administrative team and integrated healthcare coaches are available to support the development of your Integration Enhancement Plans.

Date:

Organization Profile

- a. Primary Applicant (Organization):
- b. Physical Address:
- c. Mailing Address:
- d. Telephone Number:
- e. Organization Type (primary care, behavioral health, community service, etc.):
- f. Primary Organization Contact Person:
Name:
Title:
Email:
Telephone:
- g. Please list the names of all other organizations included on this application:

Integration Plan Overview

- a. Budget Dollars Requested (by DSRIP program years (2018, 2019, 2020):
*(Please see **Appendix C** for the Allowable Use of NH DSRIP funds)*
- b. Anticipated Project Start Date:
- c. Anticipated Project End Date:

- a. Please provide a description of the proposed Integration Enhancement project.
- b. Include a description of the collaborative approach taken in the proposed project, including established and future relationships with partners. Identify opportunities to strengthen the collaborative approach and any anticipated challenges to the proposed collaboration. If a collaborative approach is not needed for this project, please explain why.
 - a. *Please include any social services or community support organizations for which you currently have relationships or with whom you are interested in exploring partnerships around the following categories:*
 - i. *Peer Support*
 - ii. *Housing*
 - iii. *Financial Strain*
 - iv. *Family and Support Services*
 - v. *Education and Health Literacy*
 - vi. *Employment and Entitlement*
 - vii. *Transportation*
 - viii. *Legal*
 - ix. *Other:*
- c. Please describe how your organization, or collaboration of organizations, will implement the proposed project. This may include:
 - *Primary activities, proposed FTEs needed, a brief job description and how any positions will be supervised, mentored, trained, etc.*
 - *An implementation timetable with milestones*
 - *Operational strategy and infrastructure to execute this proposal*
 - *Use of evidence-based practices or innovative techniques*
- d. Provide a brief description regarding the commitment by the applicant's executive leadership and that of other participating organizations.
- e. Include a detailed budget for the requested funds. Please describe those funds anticipated for the initial 12 month period versus the anticipated funding needs for years 2 and 3.
 - i. *Please consider the following budget areas for the creation of a detailed project budget.*
 - Number of proposed FTEs
 - Salary
 - Benefits
 - Any supervision costs associated with new FTEs
 - Recruitment costs
 - Training costs
 - Occupancy
 - Technology costs (hardware, software, etc.)
 - Administrative expenses (supplies, printing, etc.)
 - Travel
 - Other (please describe each in a separate line)
 - Total budget

If your project proposal and budget includes multiple applicants, please identify (if applicable) how the funds will be allocated and/or used among the organizations.

Scope of Work

B1: Integrated Healthcare Project Summary

Per the Delivery System Reform Incentive Payments (DSRIP) project Special Terms and Conditions, all primary care, mental health and substance use disorders providers who are Network4Health IDN partners are required to participate in the Integrated Healthcare project. The Administrative Leadership team and Integrated Healthcare Project Team will work with the respective providers to determine the optimal time to implement this project in their practices. Integration Plans should align with the strategic goals of your organization and partnerships, while also addressing the goals and core components of the NH DSRIP Integrated Healthcare Project.

Your Integration Plan should demonstrate how the following components of Coordinated Care Collaboration or Integrated Care Collaboration will be addressed by your organization(s). For additional details, please review the Integrated Healthcare Project Scope of Work Details as defined by NH DSRIP and Network4Health in **Appendix A** of this document.

- All participants will demonstrate how the practice or a collaboration of practices will achieve the *Coordinated Care Practice or Integrated Care Practice* designation by December 2018.
 - Required components of the *Coordinated Care Practice* designation include the following:
 - Comprehensive Core Standardized Assessment Process
 - Shared Care Plan (*NOTE: Network4Health Health Information Technology workgroup will adopt a Shared Care Plan and supportive technologies that will be available to all Network4Health Partners*)
 - Multi-Disciplinary Core Team
 - Information Sharing Demonstrated Through Care Plans, Treatment Plans and Case Conferences
 - Standardized Workflows and Protocols
 - Staff training is required in the following areas*:
 - All participants
 - Comprehensive Core Standardized Assessment implementation
 - Cultural Competence for Mental Health and Substance Use Disorders
 - For Primary Care Organizations
 - Behavioral Health Overview Training
 - SBIRT (if your organization has not yet implemented this tool)
 - For Behavioral Health Organizations
 - Chronic Disease Training that covers Diabetes/Hyperglycemia, Dyslipidemia and Hypertension
- *Network4Health will provide funding and coordination of required trainings through the Network4Health Workforce Development project**
- Additional training is encouraged and should be documented in your IEP. Additional funds are available through the Network4Health Workforce Development project. Please note the desired training, as well as the type of staff to be trained (providers, clinicians,

non-clinical staff) and the volume of staff to train. Suggested trainings to consider for your IEP:

- Mental Health First Aid
 - Recovery and Recovery Support
 - Prescription Drug Misuse and Abuse
 - Motivational Interviewing
- **Required components of the *Integrated Care Practice* designation include the following:**
 - All the above Coordinated Care Practice components
 - 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)
 - Use of technology to identify at-risk patients, plan their care, monitor/manage patient progress toward goals, ensure closed loop referrals.

Integration Enhancement Plans should include how the practice or collaboration of practices will operationalize the above requirements and how funding will be used to implement this plan.

Network4Health will fund 2 cohorts (waves) of practices, one in late 2017 and the second will kick-off in February 2018. The Network4Health Project Advisory Board has selected to use the **Site Self-Assessment Survey (SSA)** provided by the NH Citizens Health Initiative; an 18-question consensus based survey regarding your practices current status along several dimensions of integrated care. The baseline results of this short self-reported survey are meant to stimulate conversations among your care team members about where your organization currently is along the continuum of integrated care and kick-off the development of your Integration Plan.

All primary care and behavioral health providers/organizations are encouraged to speak directly with any member of the administrative lead team or the Integrated Healthcare project chairs about readiness and timing for implementing this project. Please contact [REDACTED] for more information.

Recommended Comprehensive Core Standardized Assessment Screenings by Domain:

Utilization of a Comprehensive Core Standardized Assessment (CCSA) across 12 domains is an important requirement of the NH DSRIP Integrated Healthcare Project for all participants. Demonstrated use and data collection for the CCSA is tied to continued funding of your integration projects in 2019 and 2020.

The CCSA is meant to identify vulnerable or “at risk” patients for either further assessment and intervention or creation of a shared care plan to provide coordinated interventions across the patients’ core team.

In October 2017, all Network4Health cohort 1 participants were invited to participate in a CCSA workgroup to define a recommended set of screening questions across each required domain. The workgroup currently meets bi-weekly and has addressed most of the CCSA domains (as of 12/21/17). All Integration Enhancement Plans should address how your organization is currently or will be addressing

each domain, either through screenings selected by your organizations or adoption of the Network4Health recommended screening questions. The Network4Health administrative team will work closely with your organizations to understand your preferred implementation path for the CCSA both from a workflow and HIT perspective. We understand that implementation of a CCSA is not a one size fits all model for our participants and we will work with each of you to identify a feasible and Network4Health supported implementation plan.

Required CCSA Screening Domains

- Demographic
- Medical
- Substance Use including tobacco use and SBIRT screening
- Housing
- Family and Support Services
- Education/Health Literacy
- Employment and Entitlement
- Legal
- Risk Assessment (including suicide risk)
- Functional Status (ADL, iADL and Cognitive Functioning screenings)
- Developmental and Behavioral Screenings (Pediatric Population Only – screening must be done that is appropriate to age of the patient)
- Depression Screening: PHQ 2 & 9

Transformation Initiative Outcome Measures

The following outcome performance measures drive the incentive payments received each year by Network4Health from Centers for Medicaid and Medicare Services, CMS and NH DHHS. For more information, please visit the Outcome Specification Metrics starting on page 185 in the DSRIP's Special Terms and Conditions: <https://www.dhhs.nh.gov/section-1115-waiver/documents/approval-protocols.pdf>.

Of particular importance, Network4Health must calculate and submit results from the below performance measures based on participant EHR's or other manual data collection methodologies. All 7 of the NH DSRIP IDN's are working with a data aggregator service to identify data collection methods for these measures with our partner organizations.

DSRIP IDN Calculated Measures

1. **ASSESS SCREEN 1: Use of Comprehensive Core Standardized Assessment**
 - Covering 12 domains including medical, housing, legal, employment, etc

Denominator= Medicaid patients that are seen in the reporting period
Numerator = those Medicaid patients in the reporting period that have had Core Assess/ 12 domains
 2. **ASSESS SCREEN 2: Follow-up plan for positive screenings for SUD and/or Depression**

Denominator= Medicaid patients who have been screened for Depression and/or SUD and has a positive result;
Numerator is Medicaid patients that have a F/U plan
 3. **ASSESS SCREEN 3: Use of Selected USPSTF Services for behavioral health population**
 - Blood pressure screening
 - Cardiovascular disease prevention high risk
 - Diabetes screening for obese & overweight adults
 - Tobacco use interventions
 - Obesity screening and counseling adult/child
 - Lipid disorder screening high risk
 - Lipid disorder screening
 - Intimate partner violence screening

Shares similarities with nation wide standards

Denominator= any Medicaid patients with a *BH Dx, seen in the reporting period
 - participant sends MAeHC general Medicaid population for these and MAeHC to apply the filter with attribution list from DHHS after the fact - *6 mons later, DHHS will provide an attribution list that MAeHC will calculate the measure on for participant
 4. **ASSESS SCREEN 4: Smoking and tobacco cessation screening and counseling**

This measure is exactly aligned with the CMS measure
 5. **CARE 03: Hypertension -- Controlling high blood pressure**
 6. **CARE 03: Diabetes -- HbA1C control**
- These are "hybrid" measures – MAeHC sending the clinical data & DHHS calculates measure combining w/claims data - 2018 time period forward**
These are HEDIS based measures and will be calculated on attributed Medicaid population
- **Historical data also required for 2015, 2016, 2017 for establishing baseline**

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

*** Not specific to Direct; flexible as to modality of transport.**

Appendix A

NH DSRIP Integrated Healthcare Project Scope

Goal: Build a delivery system that effectively and efficiently prevents, treats, and manages acute and chronic behavioral health and physical illnesses across multiple providers and social support agencies.

Description: The integration of care across primary care, mental health, substance use disorder and social support service providers is a foundational core competency requirement for participants in the demonstration. This project will assist primary care and behavioral health providers in reaching the highest feasible level of integrated care based on the approach described in SAMHSA’s Standard Framework for Levels of Integrated Healthcare (<http://www.integration.samhsa.gov/about-us/pbhci>).

Target Population: Medicaid beneficiaries with behavioral health conditions or at risk for such conditions will be the primary sub-population expected to benefit from the project.

Target Participating Organizations: Organizations or individual IDN network providers who offer primary care, mental health services, substance misuse/SUD services, and social support services.

Note: Per NH DSRIP program requirements, all primary care, mental health and substance use disorder providers are required to participate in this project.

Project Components:

- All participants will demonstrate how the practice or a collaboration of practices will achieve the Coordinated Care Practice Designation by December 2018.
- Required components of the Coordinated Care Practice Designation include the following:
 - **Comprehensive Core Standardized Assessment Process and Shared Care Plan** (*NOTE: Network4Health’s Health Information Technology Workgroup has adopted Shared Care Plan technology that will be available to partner organizations*)
 - Use of a Comprehensive Core Standardized Assessment framework that includes evidence-based universal screening for depression and SBIRT. The assessment process will be the basis for an individualized care plan used by the care team to guide the treatment and management of the target population. The assessment will include the following domains:
 - Demographic
 - Medical
 - Substance use including tobacco use and SBIRT screening
 - Housing
 - Family & support services
 - Education
 - Employment and entitlement
 - Legal
 - Risk assessment including suicide risk
 - Functional status (screenings for all three of the following must be done for completion of this category: activities of daily living, instrumental activities of daily living, cognitive functioning)
 - Developmental and Behavioral Screenings (Pediatric Population Only – screening must be done that is appropriate to age of the patient)

- Depression Screening: PHQ 2 & 9
 - **Note:** The Network4Health CCSA workgroup is in the process of completing recommendations for evidence-based screenings that capture the above domains. If an organization prefers to use a different assessment tool or to leverage existing tools that capture the above domain areas, please provide a copy of the assessment tool(s).
- **Multi-Disciplinary Core Team**
 - Development of a multi-disciplinary core team available to support individuals at risk for or with diagnosed behavioral health conditions or chronic conditions that includes PCPs, behavioral health providers (including a psychiatrist), and assigned care managers or community health worker. Teams may also include peer specialists, pharmacists, social support service providers and pediatric providers as appropriate.
 - Core team members are not required to be physically co-located or to be part of the same organization, although co-location is strongly encouraged where feasible given the size and volume of a practice.
 - Required basic educational program for core team members for training in management of chronic diseases, mental health disorders and substance use disorders to enable team members to recognize the disorders and act appropriately upon the information. Practice staff not involved in direct care should also receive training in the knowledge and beliefs about mental disorders.
 - Well-defined care manager/community health worker role which includes providing support to the patient in meeting care plan goals, providing support to core team members to ensure that the teams are coordinating care and communicating effectively.
 - Demonstrated care coordination through documented work flows, joint service protocols and communication channels with community-based social support service providers.
 - Demonstrated adherence to New Hampshire Board of Medicine guidelines on opioid prescribing.
- Information Sharing Demonstrated Through Care Plans, Treatment Plans and Case Conferences
 - Documented work flow that ensures timely communication of a defined set of clinical and other information critical to diagnosis, treatment and management of care.
 - Regularly scheduled case conferences (minimum monthly) for those patients with significant behavioral health conditions or chronic conditions.
 - Documented workflows for communication protocols for how information is shared with treatment providers, community-based organizations and how privacy will be protected.
- Standardized Workflows and Protocols
 - Written roles, responsibilities and workflows for core team members.
 - Protocols to ensure safe care transitions from institutional settings back to primary care, behavioral health and social support services providers.
 - Intake procedures that include systematically soliciting patient consent to confidentially share information among providers. (*NOTE: Network4Health will be supporting and coordinating discussions around patient consent with participants.*)

- **Additional Integrated Practice designation requirements:**
 - All of the requirements for the Coordinated Care Practice designation above
 - Adoption of both of the following evidence-based interventions:
 1. Medication-assisted treatment (MAT)
 2. Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., through use of the IMPACT or other evidence-supported model)
 - Use of technology to identify at-risk patients, plan their care, monitor/manage patient progress toward goals, ensure closed loop referral. Such tools will include a shared or interoperable EHR and/or electronic care

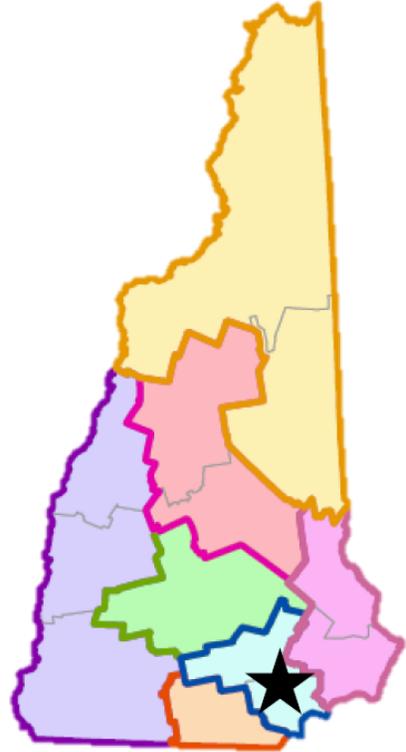
Appendix B

Network4Health Region 4 IDN Geography

4. Derry and Manchester

6

Cities and Towns in Proposed IDN #4		
Atkinson	Deerfield	Manchester
Auburn	Derry	New Boston
Bedford	Goffstown	Plaistow
Candia	Hampstead	Salem
Chester	Hooksett	Sandown
Danville	Londonderry	Windham



Appendix C

Network4Health Partner Organizations

Organization Name	Organization Type
Catholic Medical Center (Lead) including Health Care for The Homeless.	Hospital and primary care organization
American Medical Response of MA	Other
Ascentria Care Alliance	Community-Based Organization providing social and support services
Bhutanese Community of NH	Community-Based Organization providing social and support services
NH Catholic Charities Catholic Charities NH	Other
Center for Life Management	MHC
Child and Family Services	Social Services
City of Manchester Health Department	Public Health Organization
Community Crossroads	Home and Community Based Care Provider
Crotched Mountain	Community-Based Organization providing social and support services
Dartmouth Hitchcock Manchester/Bedford	Hospital
Derry Friendship Center	Other
Easter Seals NH, including Farnhum Center	Community-Based Organization providing social and support services and SUD Treatment
Elliot Health System	Hospital and primary care organization
Families in Transition	Community-Based Organization providing social and support services
Goodwill Industries of Northern New England	Community-Based Organization providing social and support services
Granite Pathways	Community Based Organization providing social services and supports
Granite State Independent Living	Home and Community Based Care Provider
Granite United Way	Host Agency for the South Central Public Health Network, Administrative Lead for 211-NH
Greater Derry Community Health Services, Inc.	Non Profit H&HS
Hillsborough County	County Corrections; Nursing Facility
Home Health and Hospice Care	Home and Community Based Care Provider

Organization Name	Organization Type
Hope for NH Recovery	Community Based Organization providing social and support services
International Institute of New England	Other
Life Coping Inc.	Home and Community Based Care Provider
Makin' It Happen	Public Health Organization
Manchester Community Health Center	Federally Qualified Health Center
Manchester Housing and Redevelopment Authority	Other
Manchester School District	Other
NAMI NH	Community Based Organization providing social services and supports
New Hampshire Hospital*	Hospital
New Horizons for NH	Community Based Organization providing social services and supports
NH Legal Assistance/NH Medical Legal Partnership	Other
On the Road to Wellness	Non-CMHC Mental Health Provider
Parkland Medical Center	Hospital
Pastoral Counseling Services	Mental Health Providers
Rockingham County	County Corrections; Nursing Facility
Serenity Place	SUD Treatment
ServiceLink Aging and Disability Resource Center of Rockingham County	Community Based Organization providing social services and supports
Southern New Hampshire Services	Community Based Organization providing social services and supports
St. Joseph Community Services, Inc.	Other
The Mental Health Center of Greater Manchester	MHC
The Moore Center	Community Based Organization providing social services and supports
The Upper Room	Community Based Organization providing social services and supports

* 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.

Appendix D

Allowable Expenditures

Please see below for approved project expenditures for the DSRIP project:

- **Capacity building for direct care or service provision workforce: Recruitment and Hiring**— Funds can be used to support the recruitment and hiring of front-line staff involved in the direct delivery of health care, behavioral health care (mental health and substance use disorder), or social services, with a focus on job categories associated with regional service gaps and shortages identified in Section V. These activities may include the development of job descriptions, advertising of positions, interviewing, and onboarding of inexperienced staff.
- **Capacity building for direct care or service provision workforce: Retention of existing staff**—Funds can be used to promote retention of existing front-line staff involved in the direct delivery of health care, behavioral health care, or social services, in job categories associated with regional service gaps and shortages identified in Section V. This may include reasonable compensation adjustments, professional development programs, cross-training initiatives, and other retention strategies.
- **Capacity building for direct care or service provision workforce: Training**—Funds can be used to support training/re-training of front-line staff involved in the direct delivery of health care, behavioral health care, or social services, with a focus on job categories associated with regional service gaps and shortages identified in Section V. This may include the identification of training needs, the development of training curricula, and training deployment/delivery.
- **Health Information Technology/Exchange.** Funds can be used for investments in critical Health Information Technology/Exchange infrastructure, which may include EMR/Electronic health record systems, registry capacity, embedding of core standardized assessments into existing systems, enabling of common treatment plans and care transition plans to be shared between providers across sites of service, health information exchange, etc.

Non-Allowable Expenditures

According to the regulations provided to us by the State of New Hampshire, the following items are non-allowable expenditures by DSRIP Funds:

- Alcoholic beverages
- Debt restructuring and bad debt
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations and Contributions
- Entertainment
- Capital expenditures for general purpose equipment, building and land, with the exception of costs associated with information technology requirements for the demonstration
- Fines and penalties
- Fund raising and investment management costs
- Goods or services for personal use
- Idle facilities and idle capacity

Attachment_B1.2a

- Insurance and indemnification
- Interest expense
- Lobbying, as defined under NH law
- Memberships and subscription costs
- Patient costs

Please note: The above list of non-allowable expenditures is not exclusive.

Shared Care Plan Task Force Recommendations To the IDN Leads

November 17, 2017

Agenda

Recommendations to IDN Leads

Background – Making Room For Multiple Care Coordination Models

Appendix

Introduction

Introduction:

- The Shared Care Plan Task Force was formed as a short term, multi-IDN working group to discuss and come to consensus in two areas required for launch of shared care planning:
 - Initial Data Convention
 - Privacy Policy Guardrails
- ~50 individuals from the 7 IDNs came together for 3 planning sessions (Oct 27, Nov 3, Nov 10)
- The Task Force discussed “straw-person” positions regarding shared care planning and related privacy policy. We tested levels of agreement throughout and made changes in all areas of disagreement until we reached full consensus.
- There was one large sticking point regarding models for shared care planning throughout the state. This was accommodated with an incremental approach (details provided later in this presentation).
- The following consensus recommendations are offered by the Task Force to the IDN leads and their respective governance bodies for consideration

Caveats Up Front

Caveats up front:

1. This privacy policy guardrails are for consideration but are not legal advice. IDNs and their participants should engage legal guidance as they see fit.
2. Privacy policy guardrails build upon the discovery work of others:
 - Multi-IDN privacy boot camp – commissioned by IDNs and supported by UNH law under direction of Lucy Hodder
 - Pre-Managed Software Service review of Federal and NH state laws, commissioned by Collective Medical Technologies, Inc. and completed by Foley & Lardner LLP March 14, 2017

Recommendation #1

Initial Data Convention for Shared Care Plan

The Shared Care Plan Task Force recommends to the IDN Leads that we pursue a simple and flexible statewide convention for shared care plans comprising 4 high value data elements:

- 1. Care Team*
- 2. Person-Centered Goals*
- 3. Concerns*
- 4. Plan*

The Task Force recommends additional exploration in these areas:

- 1. Consent tracking*
- 2. Documentation best practice development with clinicians*
- 3. Referral tracking*

Shared Care Plan Data Field Descriptions

Data Field	Description
Care Team	List of current care providers (medical and community supports) and their contact information
Person-Centered Goals	A Medicaid Member-defined outcome or condition to be achieved in the process of care. (e.g., alleviation of health concerns, desired/intended positive outcomes from interventions, longevity, function, symptom management, comfort, wellness, stability)
Concerns	A Medicaid Member and/or Care Team-defined interest or worry about a Member that may require attention, intervention, or management. (e.g., Homelessness, Food insecurity, Domestic Violence, Schizophrenia, Diabetes)
Plan	A Care Team plan for addressing Goals and Concerns. Forward looking plan that helps orchestrate actions of the Care Team and Community Support providers.

Recommendation #2 (1 of 2)

Initial Privacy Policy Guardrails for Shared Care Plan

The Shared Care Plan Task Force recommends to the IDN Leads that we begin Shared Care Planning with the following Privacy Policy Guardrails:

1. *Sharing of Personal Health Information (PHI) in shared care planning sessions or in shared care plans is permitted among HIPAA Covered Entities (CEs) and their Business Associates (BAs) for purposes allowed under HIPAA.*
2. *There will be no disclosure of Psychotherapy Notes in shared care planning sessions or in a shared care plan.*
3. *Written Consent is required for disclosure of sensitive information in shared care planning sessions or in a shared care plan including:*
 - a) *Substance Use Disorder Treatment information provided by “part 2” program (including written consent for re-disclosure)*
 - b) *Information pertaining to HIV test results*
 - c) *Information pertaining to involuntary admissions*
 - d) *Information pertaining to Members in Mental Health Programs*

Recommendation #2 (2 of 2)

Initial Privacy Policy Guardrails for Shared Care Plan

The Shared Care Plan Task Force recommends to the IDN Leads that we begin Shared Care Planning with the following Privacy Policy Guardrails:

- 4. Community Organizations that are not HIPAA CEs or BAs may participate in shared care planning where no PHI is disclosed.*
- 5. Community Organizations that are not HIPAA CEs or BAs may participate in shared care planning and/or Access a Shared Care Plan where PHI is disclosed only when written consent to disclose information to the organization has been obtained from the Medicaid Member (subject to shared care plan vendor capabilities).*
- 6. Member and Caregiver will have Access to Shared Care Plan via Paper Copy and will be provided a process for Corrections*

Agenda

Recommendations to IDN Leads

Background – Making Room For Multiple Care Coordination Models

Appendix

Aspirations and Constraints

Aspirations

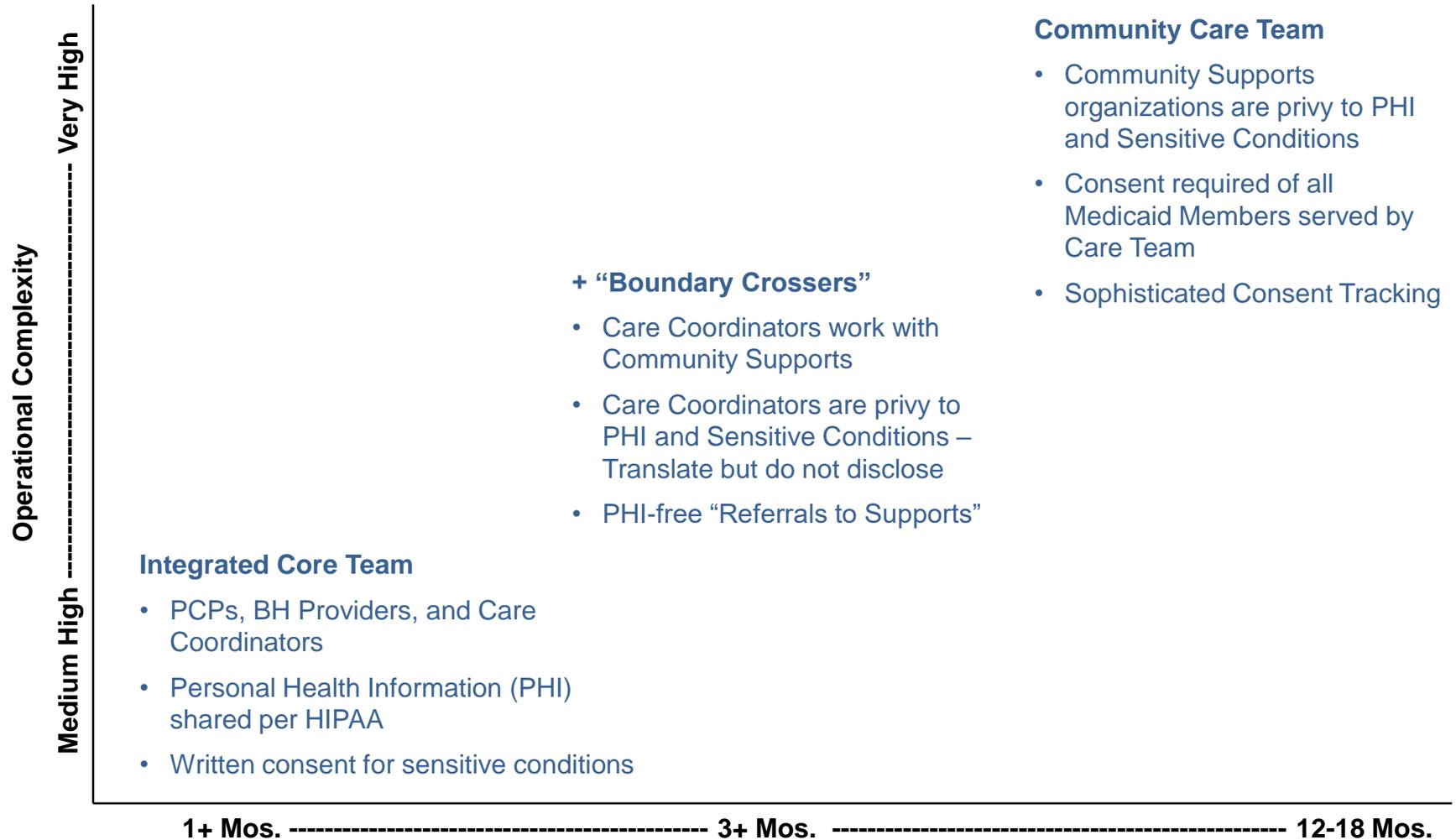
- Improve well-being for Medicaid Members
- Coordinate / Integrate Community Support and Medical Supports
- Re-imagine our system of support for Medicaid Members
 - Be Disruptive where needed to move the system forward
- Protect Medicaid Member Privacy and Choice

Constraints

- Federal and State rules and laws that significantly constrain information sharing
- Payment models that may run counter to aspirations
- Short window of opportunity to move from ideation to operations and to demonstrate results (3 years 2018-2020)
- Highly-prescribed program requirements closely tied to program revenue

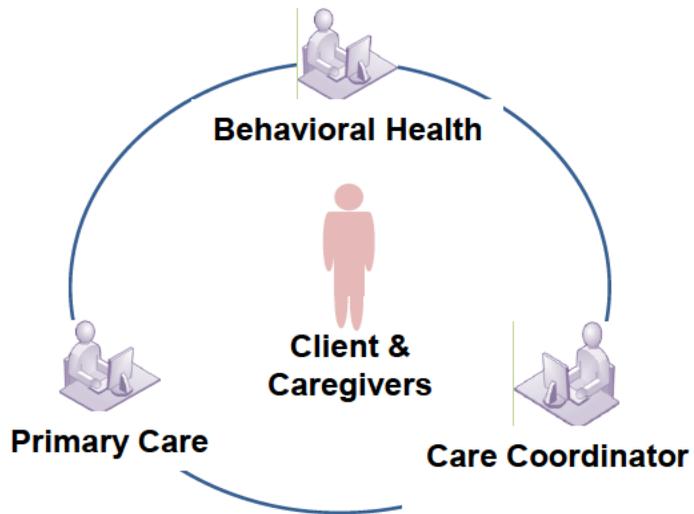


An Incremental Approach To Shared Care Planning



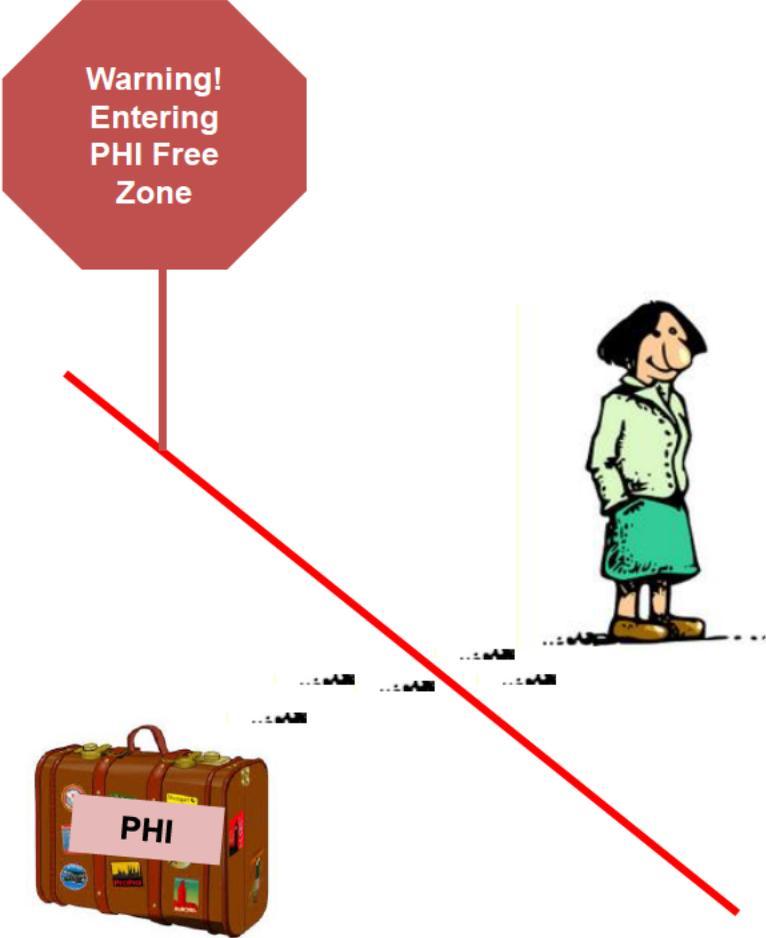
1. Integrated Core Team

Integrated Core Team

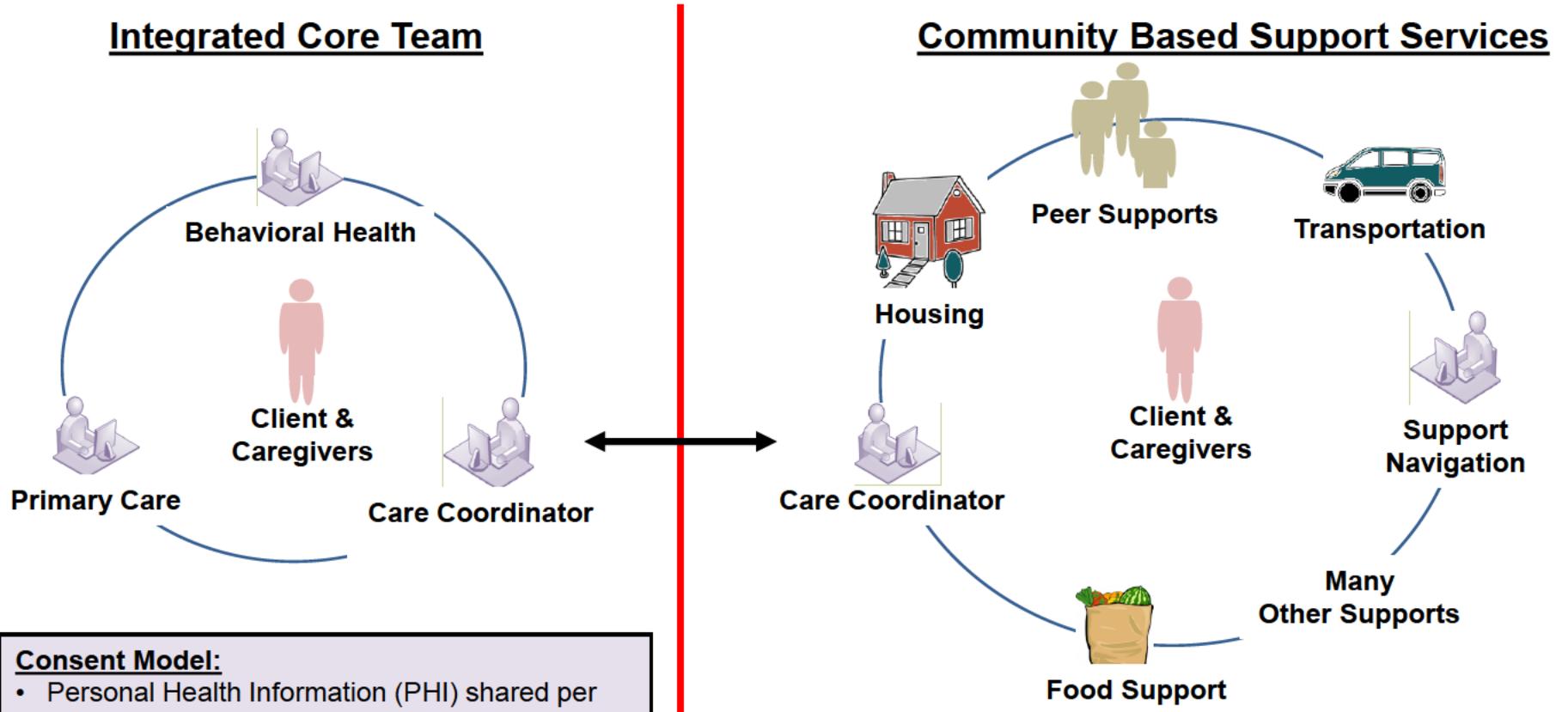


Consent Model:

- Personal Health Information (PHI) shared per HIPAA
- Written consent for sensitive conditions



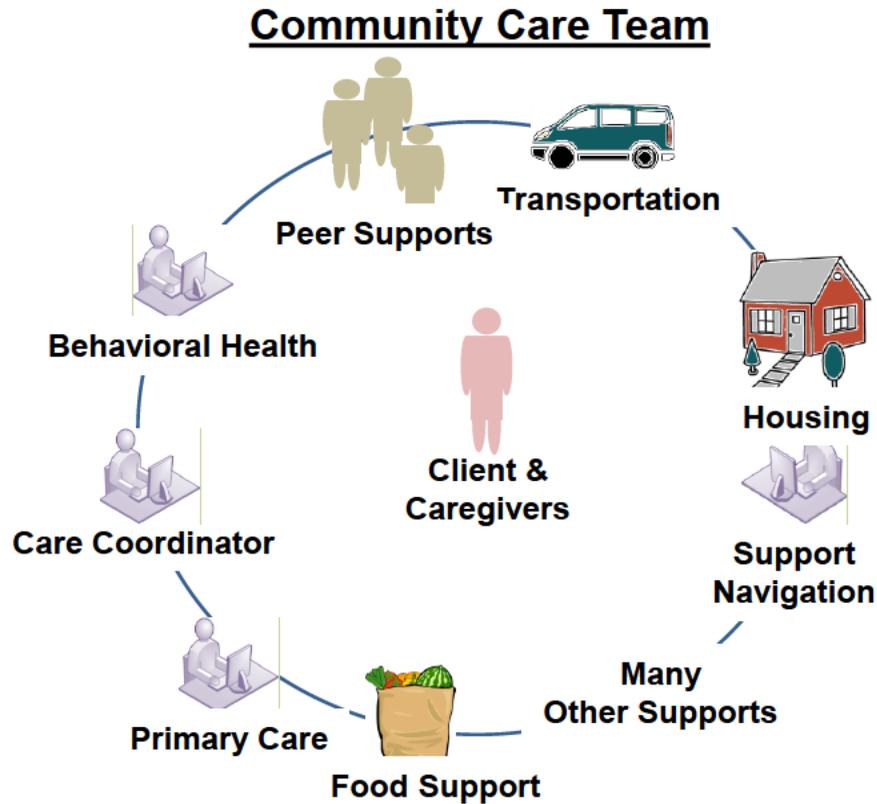
2. Integrated Core Team + “Boundary Crossers”



Consent Model:

- Personal Health Information (PHI) shared per HIPAA
- Written consent for sensitive conditions
- Care Coordinators are privy to but do not disclose PHI and Sensitive Conditions

3. Community Care Team



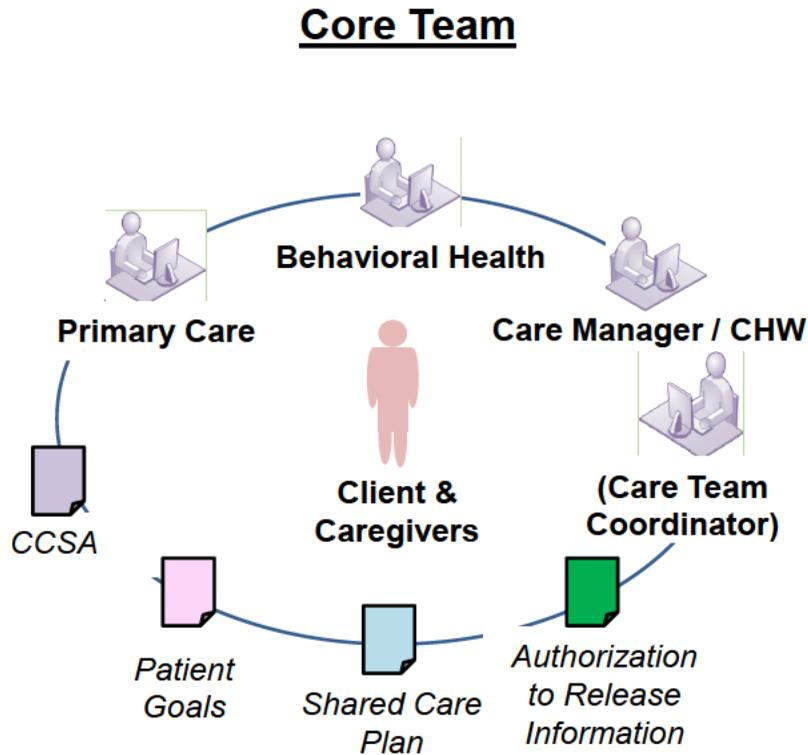
Consent Model:

- Consent required of all Medicaid Members served by Care Team
- Technical and Policy controls required for Community Organization access

Agenda

Appendix

Integrated Care Framework



DHHS-CMS Requirements

Comprehensive Core Standardized Assessment and Shared Care Plan:

The assessment process will be the basis for an individualized care plan used by the care team to guide the treatment and management of the target subpopulation

Multi-Disciplinary Core Team:

PCP, BH Providers (including psychiatrist), Care Manager/Community Health Worker (CHW)

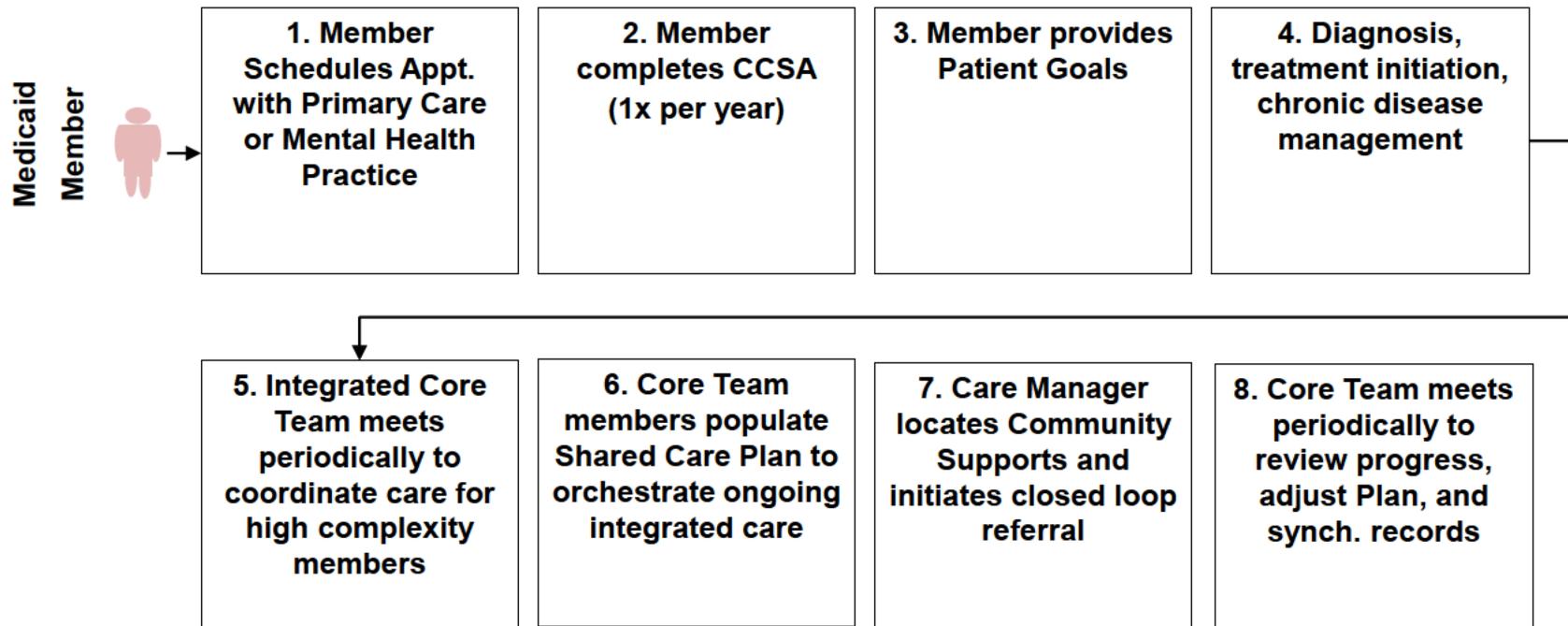
Information sharing:

Care plans, monthly case conferences for complex patients, and protocols for sharing information while protecting patient privacy

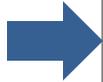
Standardized workflows and protocols:

Roles & responsibilities for core team members, protocols for safe care transitions, and intake procedures to solicit patient consent to share information among providers

Integrated Care Workflow for High Complexity Medicaid Members (non-acute)



Shared Care Plan Example (1 of 4)



Care Team:

Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:

Health Concerns:

Plan of Treatment:

Shared Care Plan Example (2 of 4)

Care Team:

Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:



Prevent the voices in my head from getting louder in the evenings
Continue working part time and volunteering

Health Concerns:

Plan of Treatment:

Shared Care Plan Example (3 of 4)

Care Team:

Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:

Prevent the voices in my head from getting louder in the evenings
Continue working part time and volunteering

Health Concerns:

Schizophrenia
Social isolation
Member manages voices in head by going to the ED non-emergency
4 years since last visit to primary care

Plan of Treatment:



Shared Care Plan Example (4 of 4)

Care Team:

Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:

Prevent the voices in my head from getting louder in the evenings
Continue working part time and volunteering

Health Concerns:

Schizophrenia
Social isolation
Member manages voices in head by going to the ED non-emergency
4 years since last visit to primary care

Plan of Treatment:

In the ED: Contact CMHC on call nurse 603-123-4567. ED diversion plan on file.

Refer to peer support organization for evening volunteer and social support opportunities
(Status: Open) (Owner: CMHC Case Manager)

Recommend getting a companion pet at next visit (Status: Open) (Owner: CMHC Counselor)

Continue to manage Schizophrenia with current plan. Plans on file (Status: Ongoing)
(Owner: CMHC, Psychiatry Specialist)

Schedule annual well visit with PCP (Status: Open) (Owner: CMHC Case Manager)



Initial Privacy Guard Rail: Consent Required for Members in Part 2 Substance Use Disorder Treatment Programs

Draft Privacy Policy:

Substance Use Disorder Providers that hold themselves out as “part 2” providers shall obtain written consent from individuals to participate in Shared Care Planning.

Policy basis:

- 42 CFR part 2, CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS <https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol1/xml/CFR-2016-title42-vol1-part2.xml>
- 42 CFR part 2 Final Rule, January 18, 2017 <https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-00719.pdf>

For discussion:

- Part 2 providers need to obtain authorization to disclose their relationship with individuals undergoing substance use disorder treatment
- Guidance and forms are available to all IDN participants from the “IDN Privacy Boot Camp”

Initial Privacy Guard Rail: No disclosure of Psychotherapy Notes

Draft Privacy Policy:

Providers shall not disclose psychotherapy notes in shared care planning sessions nor in the Shared Care Plan.

Policy basis:

- HIPAA Security Rule

For discussion:

- Do we anticipate situations where psychotherapy needs to be recorded in the shared care plan?

Initial Privacy Guard Rail: No Disclosure of HIV Test Results

Draft Privacy Policy:

Providers shall disclose member information pertaining to HIV test results in the Shared Care Plan only when such information is necessary in order to protect the health of the person tested or when written consent has been obtained.)

Policy basis:

- CHAPTER 141-F, HUMAN IMMUNODEFICIENCY VIRUS EDUCATION, PREVENTION, AND CONTROL, Section 141-F:7, F:8
<http://www.gencourt.state.nh.us/rsa/html/x/141-f/141-f-mrg.htm>

For discussion:

- Do we anticipate situations where HIV status needs to be recorded in the shared care plan?
- Can disclosure of HIV status be handled between care providers and left out of the Shared Care Plan altogether?
- Physicians, Consider patient safety risks (e.g., Prescribing to patients using immune suppressants)

Initial Privacy Guard Rail: Consent Required for Members in Mental Health Programs

Draft Privacy Policy:

Mental Health Programs shall disclose member information in the Shared Care Plan only when written consent has been obtained.

Policy basis:

- NH PUBLIC HEALTH CHAPTER 135-C, NEW HAMPSHIRE MENTAL HEALTH SERVICES SYSTEM
<http://www.gencourt.state.nh.us/rsa/html/x/135-c/135-c-mrg.htm>
- He-M 300 RIGHTS He-M 309.04(f)(3)
http://www.gencourt.state.nh.us/rules/state_agencies/he-m300.html

For discussion:

- Information regarding members in Mental Health Programs is protected from disclosure without written consent
- Attorneys at DHHS and IDN-1 are looking into how broadly/narrowly this rule applies
- There are emergency exceptions

Initial Privacy Guard Rail: Consent Required for Involuntarily Admitted Members

Draft Privacy Policy:

NH Hospital, State-Designated Treatment Facilities, and Acute Psychiatric Residential Treatment Programs shall only disclose involuntarily admitted member information in the Shared Care Plan when written consent has been obtained.

Policy basis:

- NH PUBLIC HEALTH CHAPTER 135-C, NEW HAMPSHIRE MENTAL HEALTH SERVICES SYSTEM
<http://www.gencourt.state.nh.us/rsa/html/x/135-c/135-c-mrg.htm>
- He-M 300 RIGHTS He-M 309.04(f)(3)
http://www.gencourt.state.nh.us/rules/state_agencies/he-m300.html

For discussion:

- Information regarding involuntarily admitted members is protected from disclosure without written consent
- There are emergency exceptions

Initial Privacy Guard Rail: Member and Caregiver Access to Shared Care Plan via Paper Copy - Corrections

Draft Privacy Policy:

Members and/or Caregivers shall be provided with a paper copy of the Shared Care Plan upon request. Members and/or Caregivers shall be provided a process for correcting information within the shared care plans.

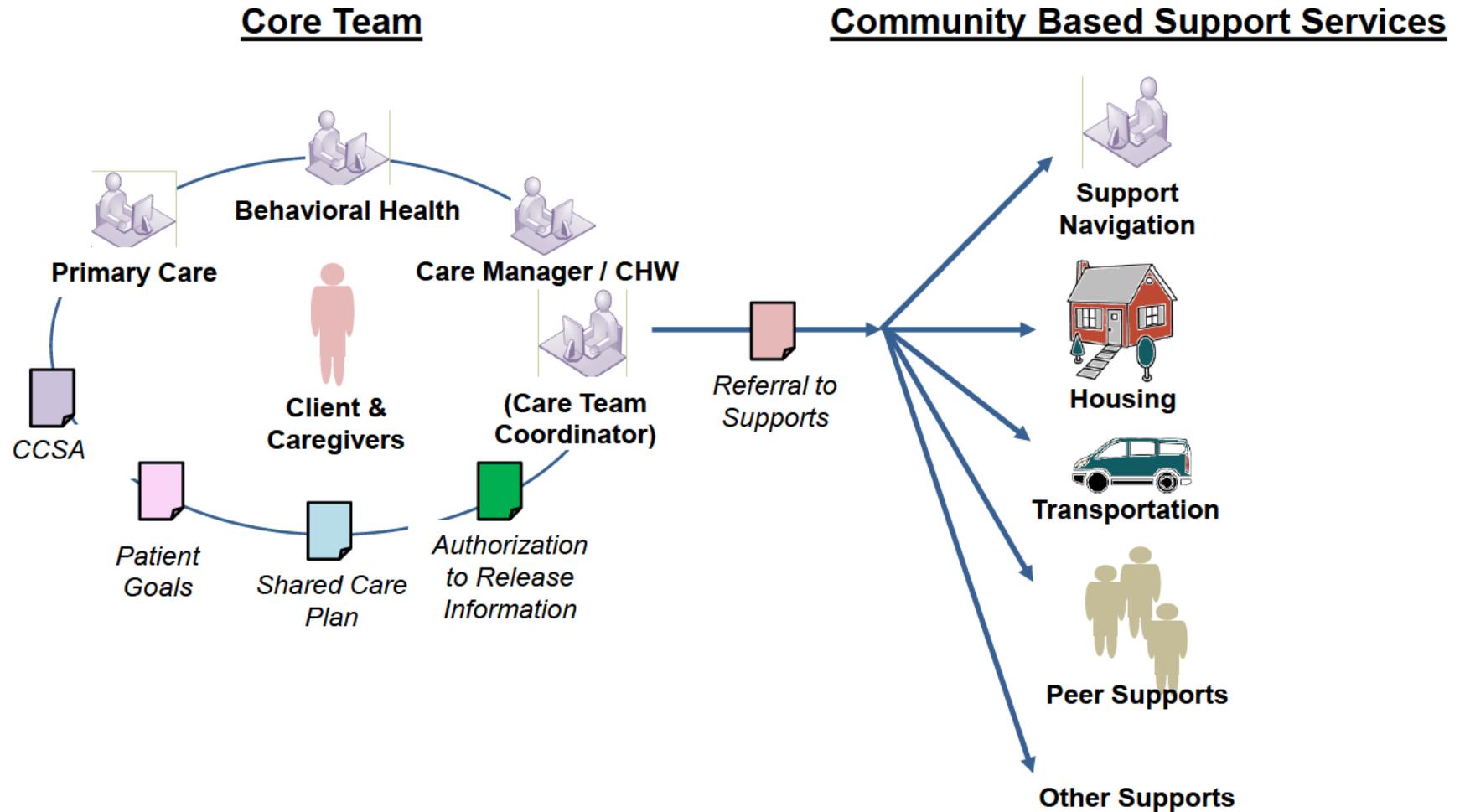
Policy basis:

- Multiple

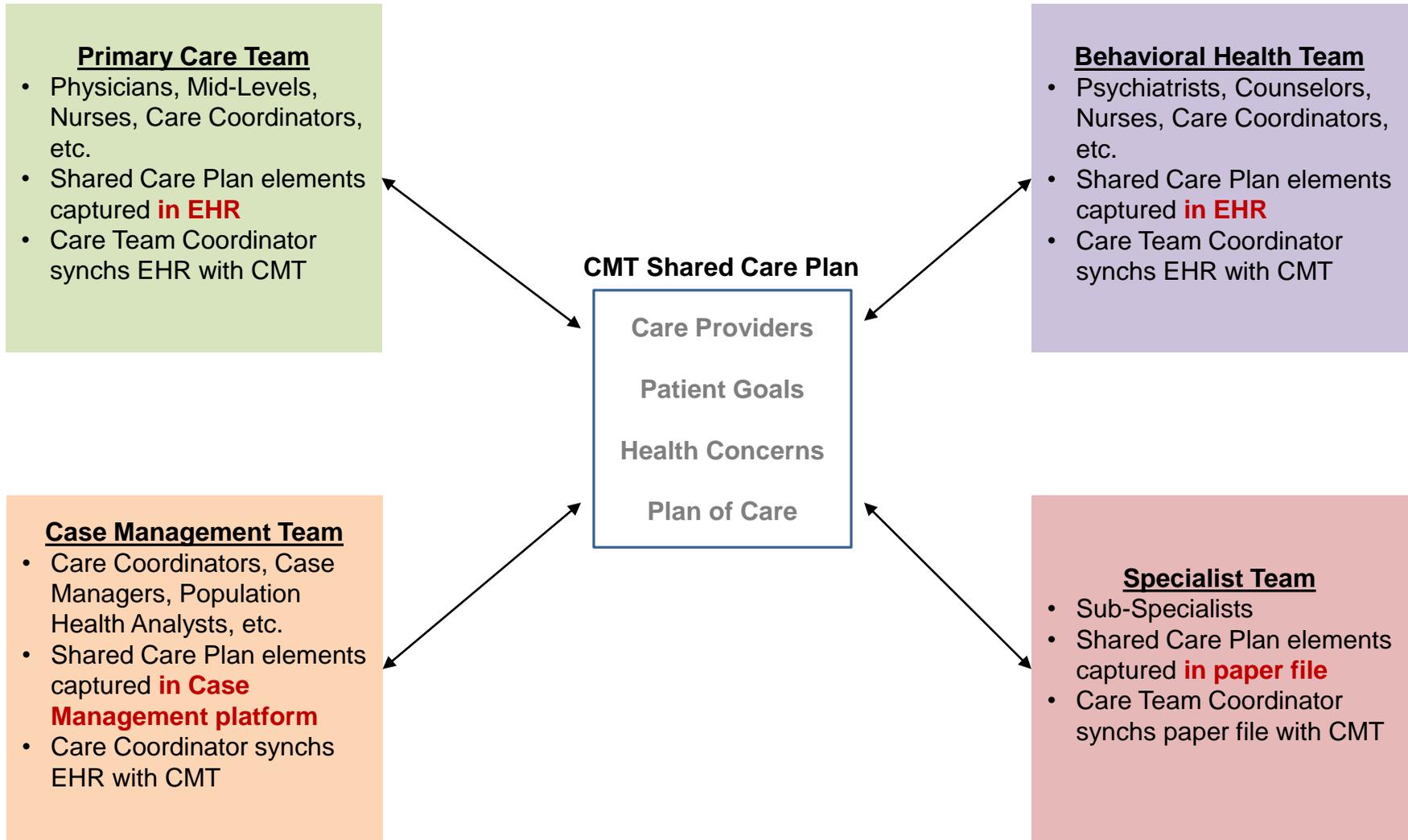
For discussion:

- Collective Medical Technology does not currently have a patient portal
- In the future we will investigate communication channels with members that have proven successful, such as EHR-tethered patient portals to share documentation
- “Open Notes” approach to documentation
- Patient ability to request changes to the record and have them recorded in shared care plan.

Core Team Engages Community Support Organizations through Discrete Referrals



Supporting Shared Care Planning with Technology



B1 - Coordinated Care - 12312017

Task Name	Duration	Start	Finish	Predecessors	% Complete
<input type="checkbox"/> B1 Integrated Healthcare - Coordinated Care Practices	307d	03/01/17	05/04/18		82%
<input type="checkbox"/> Development of Core Deliverables and Process	307d	03/01/17	05/04/18		82%
<input type="checkbox"/> Comprehensive Core Standardized Assessment Tool/Process	240d	03/01/17	01/31/18		97%
Develop Comprehensive Core Standardized Assessment Tool	50d	03/01/17	05/09/17		100%
Develop Comprehensive Core Standardized Assessment Process	25d	05/10/17	06/13/17	4	100%
Refine Comprehensive Core Standardized Assessment Process	165d	06/14/17	01/31/18	5	95%
Finalize Comprehensive Core Standardized Assessment Process	0	01/31/18	01/31/18	6	
<input type="checkbox"/> Depression Screening Tool/Process	88d	03/01/17	06/30/17		100%
Develop Depression Screening Tool	50d	03/01/17	05/09/17		100%
Develop Depression Screening Process	25d	05/10/17	06/13/17	9	100%
Refine Depression Screening Process	5d	06/14/17	06/20/17	10	100%
Finalize Depression Screening Process	8d	06/21/17	06/30/17	11	100%
<input type="checkbox"/> Shared Care Plan	307d	03/01/17	05/04/18		61%
Develop Shared Care Plan Tool	60d	03/01/17	05/23/17		100%
Develop Shared Care Plan Process	127d	05/24/17	11/16/17	14	100%
Refine Shared Care Plan Process	100d	11/17/17	04/06/18	15	
Finalize Shared Care Plan Process	4w	04/09/18	05/04/18	16	
<input type="checkbox"/> Participant Selection Process	85d	03/01/17	06/27/17		100%
Define Selection Criteria	50d	03/01/17	05/09/17		100%
Develop Selection Process	30d	05/10/17	06/20/17	19	100%
Select CHI Participants	1w	06/21/17	06/27/17	20	100%
Sign CHI Agreement (SSA administration)	22d	07/03/17	08/01/17		100%
Sign CHI Agreement (Integration Practice Facilitation)	130d	08/02/17	01/31/18	22	90%
<input type="checkbox"/> Coordinated Practice Cohort 1 (up to 20 Practices)	859d	09/15/17	02/01/21		7%
<input type="checkbox"/> CHI Assessment Cohort 1 Baseline	54d	09/15/17	11/29/17		100%
CHI Assessment Administered	21d	09/15/17	10/13/17		100%
CHI Results Collected	32d	10/16/17	11/28/17	26	100%
CHI Report Delivered	1d	11/29/17	11/29/17	27	100%
<input type="checkbox"/> Participant Implementation Process Cohort 1 Round 1	222d	11/30/17	10/11/18		5%
Up to 20 Participants Selected for Coordinated Care Practice Cohort 1	3w	11/30/17	12/20/17	28	100%
Integration Enhancement Project Team Created	1w	12/21/17	12/27/17	30	100%
Integration Enhancement Plan (IEP) Created	43d	12/28/17	02/27/18	31	
Cohort 1 IEPs Due to Network4Health	0	02/27/18	02/27/18	32	
Network4Health IEP Funding Review	10d	02/28/18	03/13/18	33	
IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	03/14/18	03/14/18	34	

Task Name	Duration	Start	Finish	Predecessors	% Complete
36 Intiate Integration Enhancement Plan - (6 months)	24w	04/03/18	09/20/18	35FS +13d	
37 3 month Status Report and Lessons Learned Due	14w	04/03/18	07/11/18	36SS	
38 6 month Status Report and Lessons Learned Due	27w	04/03/18	10/11/18	36SS	
39 - CHI Assessment Cohort 1 Follow-up 1 (Progress Assessment Checkpoint)	36d	08/30/18	10/19/18		
40 CHI Assessment Administered	3w	08/30/18	09/20/18	38FS -30d	
41 CHI Results Analysis	20d	09/21/18	10/18/18	40	
42 CHI Report Delivered	1d	10/19/18	10/19/18	41	
43 - Participant Implementation Process Cohort 1 Round 2	146d	10/22/18	05/20/19		
44 Status Report and CHI Assessment Results Reviewed	1w	10/22/18	10/26/18	38, 42	
45 IEP Modifications and Continued Funding Requests Reviewed	1w	10/29/18	11/02/18	44	
46 IEP Continuation and Funding Continuation Confirmation	1d	11/05/18	11/05/18	45	
47 Integration Enhancement Plan Continuation- (6 months)	24w	11/06/18	04/29/19	46	
48 3 month Status Report and Lessons Learned Due	14w	11/06/18	02/18/19	47SS	
49 6 month Status Report and Lessons Learned Due	27w	11/06/18	05/20/19	47SS	
50 - CHI Assessment Cohort 1 Follow-up 2 (Progress Assessment Checkpoint)	36d	04/09/19	05/29/19		
51 CHI Assessment Administered	3w	04/09/19	04/29/19	49FS -30d	
52 CHI Results Collected	20d	04/30/19	05/28/19	51	
53 CHI Report Delivered	1d	05/29/19	05/29/19	52	
54 - Participant Implementation Process Cohort 1 Round 3	146d	05/30/19	12/26/19		
55 Status Report and CHI Assessment Results Reviewed	1w	05/30/19	06/05/19	49, 53	
56 IEP Modifications and Continued Funding Requests Reviewed	1w	06/06/19	06/12/19	53, 55	
57 IEP Continuation and Funding Continuation Confirmation	1d	06/13/19	06/13/19	56	
58 Integration Enhancement Plan Continuation- (6 months)	24w	06/14/19	12/03/19	57	
59 3 month Status Report and Lessons Learned Due	14w	06/14/19	09/20/19	58SS	
60 6 month Status Report and Lessons Learned Due	27w	06/14/19	12/26/19	58SS	
61 - CHI Assessment Cohort 1 Follow-up 3 (Progress Assessment Checkpoint)	36d	11/11/19	01/06/20		
62 CHI Assessment Administered	3w	11/11/19	12/03/19	60FS -30d	
63 CHI Results Collected	20d	12/04/19	01/03/20	62	
64 CHI Report Delivered	1d	01/06/20	01/06/20	63	
65 - Participant Implementation Process Cohort 1 Round 4	151d	01/07/20	08/05/20		
66 Status Report and CHI Assessment Results Reviewed	1w	01/07/20	01/13/20	60, 64	
67 IEP Modifications and Continued Funding Requests Reviewed	2w	01/14/20	01/27/20	64, 66	
68 IEP Continuation and Funding Continuation Confirmation	1d	01/28/20	01/28/20	67	
69 Integration Enhancement Plan Continuation- (6 months)	24w	01/29/20	07/15/20	68	
70 3 month Status Report and Lessons Learned Due	14w	01/29/20	05/05/20	69SS	
71 6 month Status Report and Lessons Learned Due	27w	01/29/20	08/05/20	69SS	

Task Name	Duration	Start	Finish	Predecessors	% Complete
72 <input type="checkbox"/> CHI Assessment Cohort 1 Follow-up 4 (Progress Assessment Checkpoint)	36d	06/25/20	08/13/20		
73 CHI Assessment Administered	15d	06/25/20	07/15/20	71FS -30d	
74 CHI Results Collected	20d	07/16/20	08/12/20	73	
75 CHI Report Delivered	1d	08/13/20	08/13/20	74	
76 <input type="checkbox"/> Participant Implementation Process Cohort 1 Round 5	116d	08/14/20	02/01/21		
77 Status Report and CHI Assessment Results Reviewed	1w	08/14/20	08/20/20	71, 75	
78 IEP Modifications and Continued Funding Requests Reviewed	2w	08/21/20	09/03/20	75, 77	
79 IEP Continuation and Funding Continuation Confirmation	1d	09/04/20	09/04/20	78	
80 Integration Enhancement Plan Continuation- (4 months)	16w	09/08/20	01/04/21	79	
81 4 month Status Report and Lessons Learned Due	20d	01/05/21	02/01/21	80	
82 <input type="checkbox"/> Coordinated Practice Cohort 2 (up to 20 Practices)	690d	03/01/18	11/13/20		
83 <input type="checkbox"/> CHI Assessment Cohort 2 Baseline	41d	03/01/18	04/26/18		
84 CHI Assessment Administered	20d	03/01/18	03/28/18		
85 CHI Results Collected	20d	03/29/18	04/25/18	84	
86 CHI Report Delivered	1d	04/26/18	04/26/18	85	
87 <input type="checkbox"/> Participant Implementation Process Cohort 2 Round 1	181d	04/27/18	01/16/19		
88 Up to 20 Participants Selected for Coordinated Care Practice Cohort 2	1w	04/27/18	05/03/18	86	
89 Integration Enhancement Project Team Created	4d	05/04/18	05/09/18	88	
90 Integration Enhancement Plan (IEP) Created	3w	05/10/18	05/31/18	89	
91 Cohort 1 IEPs Due to Network4Health	0	05/31/18	05/31/18	90	
92 Network4Health IEP Funding Review	8d	06/01/18	06/12/18	91	
93 IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	06/13/18	06/13/18	92	
94 Intiate Implementation Plan - (6 months)	24w	07/03/18	12/21/18	93FS +13d	
95 3 month Status Report Due	14w	07/03/18	10/10/18	94SS	
96 6 month Status Report Due	27w	07/03/18	01/16/19	94SS	
97 <input type="checkbox"/> CHI Assessment Cohort 2 Follow-up 1 (Progress Assessment Checkpoint)	41d	12/03/18	01/31/19		
98 CHI Assessment Administered	20d	12/03/18	01/02/19	96FS -30d	
99 CHI Results Collected	20d	01/03/19	01/30/19	98	
100 CHI Report Delivered	1d	01/31/19	01/31/19	99	
101 <input type="checkbox"/> Participant Implementation Process Cohort 2 Round 2	151d	02/01/19	09/03/19		
102 Status Report and CHI Assessment Results Reviewed	1w	02/01/19	02/07/19	96, 100	
103 IEP Modifications and Continued Funding Requests Reviewed	2w	02/08/19	02/21/19	102	
104 IEP Continuation and Funding Continuation Confirmation	1d	02/22/19	02/22/19	103	
105 Integration Enhancement Plan Continuation- (6 months)	24w	02/25/19	08/12/19	104	
106 3 month Status Report and Lessons Learned Due	14w	02/25/19	06/03/19	105SS	
107 6 month Status Report and Lessons Learned Due	27w	02/25/19	09/03/19	105SS	

	Task Name	Duration	Start	Finish	Predecessors	% Complete
108	<input type="checkbox"/> CHI Assessment Cohort 2 Follow-up 2 (Progress Assessment Checkpoint)	41d	07/23/19	09/18/19		
109	CHI Assessment Administered	20d	07/23/19	08/19/19	107FS -30d	
110	CHI Results Collected	20d	08/20/19	09/17/19	109	
111	CHI Report Delivered	1d	09/18/19	09/18/19	110	
112	<input type="checkbox"/> Participant Implementation Process Cohort 2 Round 3	146d	09/19/19	04/16/20		
113	Status Report and CHI Assessment Results Reviewed	1w	09/19/19	09/25/19	107, 111	
114	IEP Modifications and Continued Funding Requests Reviewed	1w	09/26/19	10/02/19	113	
115	IEP Continuation and Funding Continuation Confirmation	1d	10/03/19	10/03/19	114	
116	Integration Enhancement Plan Continuation- (6 months)	24w	10/04/19	03/26/20	115	
117	3 month Status Report and Lessons Learned Due	14w	10/04/19	01/16/20	116SS	
118	6 month Status Report and Lessons Learned Due	27w	10/04/19	04/16/20	116SS	
119	<input type="checkbox"/> CHI Assessment Cohort 2 Follow-up 3 (Progress Assessment Checkpoint)	41d	02/26/20	04/22/20		
120	CHI Assessment Administered	20d	02/26/20	03/24/20	109FS +130d	
121	CHI Results Collected	20d	03/25/20	04/21/20	120	
122	CHI Report Delivered	1d	04/22/20	04/22/20	121	
123	<input type="checkbox"/> Participant Implementation Process Cohort 2 Round 4	145d	04/23/20	11/13/20		
124	Status Report and CHI Assessment Results Reviewed	1w	04/23/20	04/29/20	118, 122	
125	IEP Modifications and Continued Funding Requests Reviewed	1w	04/30/20	05/06/20	124	
126	IEP Continuation and Funding Continuation Confirmation	1d	05/07/20	05/07/20	125	
127	Integration Enhancement Plan Continuation- (6 months)	24w	05/08/20	10/26/20	126	
128	3 month Status Report and Lessons Learned Due	14w	05/07/20	08/13/20	126SS	
129	6 month Status Report and Lessons Learned Due	27w	05/07/20	11/13/20	126SS	
130	<input type="checkbox"/> Evaluation Metrics Reporting (Data - per approved metrics)	919d	07/01/17	02/08/21		
131	<input type="checkbox"/> On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/31/18		
132	Prepare evaluation plan measures	152d	07/01/17	01/30/18		
133	Submit	1d	01/31/18	01/31/18	132	
134	<input type="checkbox"/> On-going data reporting for period ending 06/29/2018	152d	01/01/18	08/02/18		
135	Prepare evaluation plan measures	151d	01/01/18	08/01/18		
136	Submit	1d	08/02/18	08/02/18	135	
137	<input type="checkbox"/> On-going data reporting for period ending 12/31/2018	155d	07/01/18	02/11/19		
138	Prepare evaluation plan measures	154d	07/01/18	02/08/19		
139	Submit	1d	02/11/19	02/11/19	138	
140	<input type="checkbox"/> On-going data reporting for period ending 06/29/2019	152d	01/01/19	08/01/19		
141	Prepare evaluation plan measures	151d	01/01/19	07/31/19		
142	Submit	1d	08/01/19	08/01/19	141	
143	<input type="checkbox"/> On-going data reporting for period ending 12/31/2019	155d	07/01/19	02/10/20		

	Task Name	Duration	Start	Finish	Predecessors	% Complete
144	Prepare evaluation plan measures	154d	07/01/19	02/07/20		
145	Submit	1d	02/10/20	02/10/20	144	
146	<input type="checkbox"/> On-going data reporting for period ending 06/29/2020	153d	01/01/20	08/03/20		
147	Prepare evaluation plan measures	152d	01/01/20	07/31/20		
148	Submit	1d	08/03/20	08/03/20	147	
149	<input type="checkbox"/> On-going data reporting for period ending 12/31/2020	153d	07/01/20	02/08/21		
150	Prepare evaluation plan measures	152d	07/01/20	02/05/21		
151	Submit	1d	02/08/21	02/08/21	150	
152	<input type="checkbox"/> Process Milestones	1049d	01/01/17	02/08/21		
153	<input type="checkbox"/> Milestones for period ending 06/31/2017	152d	01/01/17	07/31/17		
154	<input type="checkbox"/> Develop Implementation Plan	152d	01/01/17	07/31/17		
155	Implementation timeline	152d	01/01/17	07/31/17		
156	Budget	152d	01/01/17	07/31/17		
157	Workforce Plan	152d	01/01/17	07/31/17		
158	Participant Selection	152d	01/01/17	07/31/17		
159	Organizational Leadership Sign-off	152d	01/01/17	07/31/17		
160	<input type="checkbox"/> Milestones for period ending 12/31/2017	153d	07/01/17	01/31/18		
161	Up to 20 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/17	01/31/18		
162	Up to 2 participants have demonstrated progress towards Integrated Care Practice	153d	07/01/17	01/31/18		
163	<input type="checkbox"/> Milestones for period ending 06/31/2018	151d	01/01/18	08/01/18		
164	Up to 40 Participating Practices have demonstrated progress towards Coordinated Care Practice	151d	01/01/18	08/01/18		
165	Up to 2 participants have demonstrated progress towards Integrated Care Practice	151d	01/01/18	08/01/18		
166	<input type="checkbox"/> Milestones for period ending 12/31/2018	154d	07/01/18	02/08/19		
167	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	154d	07/01/18	02/08/19		
168	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	154d	07/01/18	02/08/19		
169	<input type="checkbox"/> Milestones for period ending 06/31/2019	152d	01/01/19	08/01/19		
170	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	152d	01/01/19	08/01/19		
171	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	152d	01/01/19	08/01/19		
172	<input type="checkbox"/> Milestones for period ending 12/31/2019	155d	07/01/19	02/10/20		
173	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	155d	07/01/19	02/10/20		
174	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	155d	07/01/19	02/10/20		
175	<input type="checkbox"/> Milestones for period ending 06/29/20	153d	01/01/20	08/03/20		
176	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	153d	01/01/20	08/03/20		
177	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	01/01/20	08/03/20		
178	<input type="checkbox"/> Milestones for period ending 12/31/2020	153d	07/01/20	02/08/21		

Attachment_B1.2c

	Task Name	Duration	Start	Finish	Predecessors	% Complete
179	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	153d	07/01/20	02/08/21		
180	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	07/01/20	02/08/21		
181						
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B1 - Integrated Care - 12312017

Task Name	Duration	Start	Finish	Predecessors	% Complete
1 <input type="checkbox"/> B1 Integrated Healthcare - Integrated Care Practices	363d	03/01/17	07/25/18		60%
2 <input type="checkbox"/> Development of Core Deliverables and Process	363d	03/01/17	07/25/18		60%
3 <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> Shared Care Plan	307d	03/01/17	05/04/18		61%
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	100d	11/17/17	04/06/18	15	
17 Finalize Shared Care Plan Process	4w	04/09/18	05/04/18	16	
18 <input type="checkbox"/> MAT Treatment Program	363d	03/01/17	07/25/18		17%
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	
21 Refine MAT Plan/Protocol	100d	03/01/18	07/20/18	20	
22 Finalize MAT Plan/Protocol	3d	07/23/18	07/25/18	21	
23 <input type="checkbox"/> 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 <input type="checkbox"/> Integrated Practice Cohort 1 (up to 2 Practices)	859d	09/15/17	02/01/21		7%
30 <input type="checkbox"/> 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 <input type="checkbox"/> Participant Implementation Process Cohort 1 Round 1	222d	11/30/17	10/11/18		5%
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	

Task Name	Duration	Start	Finish	Predecessors	% Complete
38 Cohort 1 IEPs Due to Network4Health	0	02/27/18	02/27/18	37	
39 Network4Health IEP Funding Review	10d	02/28/18	03/13/18	38	
40 IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	03/14/18	03/14/18	39	
41 Intiate Integration Enhancement Plan - (6 months)	24w	04/03/18	09/20/18	40FS +13d	
42 3 month Status Report and Lessons Learned Due	14w	04/03/18	07/11/18	41SS	
43 6 month Status Report and Lessons Learned Due	27w	04/03/18	10/11/18	41SS	
44 - CHI Assessment Cohort 1 Follow-up 1 (Progress Assessment Checkpoint)	36d	08/30/18	10/19/18		
45 CHI Assessment Administered	3w	08/30/18	09/20/18	43FS -30d	
46 CHI Results Analysis	20d	09/21/18	10/18/18	45	
47 CHI Report Delivered	1d	10/19/18	10/19/18	46	
48 - Participant Implementation Process Cohort 1 Round 2	146d	10/22/18	05/20/19		
49 Status Report and CHI Assessment Results Reviewed	1w	10/22/18	10/26/18	43, 47	
50 IEP Modifications and Continued Funding Requests Reviewed	1w	10/29/18	11/02/18	49	
51 IEP Continuation and Funding Continuation Confirmation	1d	11/05/18	11/05/18	50	
52 Integration Enhancement Plan Continuation- (6 months)	24w	11/06/18	04/29/19	51	
53 3 month Status Report and Lessons Learned Due	14w	11/06/18	02/18/19	52SS	
54 6 month Status Report and Lessons Learned Due	27w	11/06/18	05/20/19	52SS	
55 - CHI Assessment Cohort 1 Follow-up 2 (Progress Assessment Checkpoint)	36d	04/09/19	05/29/19		
56 CHI Assessment Administered	3w	04/09/19	04/29/19	54FS -30d	
57 CHI Results Collected	20d	04/30/19	05/28/19	56	
58 CHI Report Delivered	1d	05/29/19	05/29/19	57	
59 - Participant Implementation Process Cohort 1 Round 3	146d	05/30/19	12/26/19		
60 Status Report and CHI Assessment Results Reviewed	1w	05/30/19	06/05/19	54, 58	
61 IEP Modifications and Continued Funding Requests Reviewed	1w	06/06/19	06/12/19	58, 60	
62 IEP Continuation and Funding Continuation Confirmation	1d	06/13/19	06/13/19	61	
63 Integration Enhancement Plan Continuation- (6 months)	24w	06/14/19	12/03/19	62	
64 3 month Status Report and Lessons Learned Due	14w	06/14/19	09/20/19	63SS	
65 6 month Status Report and Lessons Learned Due	27w	06/14/19	12/26/19	63SS	
66 - CHI Assessment Cohort 1 Follow-up 3 (Progress Assessment Checkpoint)	36d	11/11/19	01/06/20		
67 CHI Assessment Administered	3w	11/11/19	12/03/19	65FS -30d	
68 CHI Results Collected	20d	12/04/19	01/03/20	67	
69 CHI Report Delivered	1d	01/06/20	01/06/20	68	
70 - Participant Implementation Process Cohort 1 Round 4	151d	01/07/20	08/05/20		
71 Status Report and CHI Assessment Results Reviewed	1w	01/07/20	01/13/20	65, 69	
72 IEP Modifications and Continued Funding Requests Reviewed	2w	01/14/20	01/27/20	69, 71	
73 IEP Continuation and Funding Continuation Confirmation	1d	01/28/20	01/28/20	72	
74 Integration Enhancement Plan Continuation- (6 months)	24w	01/29/20	07/15/20	73	
75 3 month Status Report and Lessons Learned Due	14w	01/29/20	05/05/20	74SS	

Task Name	Duration	Start	Finish	Predecessors	% Complete
76 6 month Status Report and Lessons Learned Due	27w	01/29/20	08/05/20	74SS	
77 - CHI Assessment Cohort 1 Follow-up 4 (Progress Assessment Checkpoint)	36d	06/25/20	08/13/20		
78 CHI Assessment Administered	15d	06/25/20	07/15/20	76FS -30d	
79 CHI Results Collected	20d	07/16/20	08/12/20	78	
80 CHI Report Delivered	1d	08/13/20	08/13/20	79	
81 - Participant Implementation Process Cohort 1 Round 5	116d	08/14/20	02/01/21		
82 Status Report and CHI Assessment Results Reviewed	1w	08/14/20	08/20/20	76, 80	
83 IEP Modifications and Continued Funding Requests Reviewed	2w	08/21/20	09/03/20	80, 82	
84 IEP Continuation and Funding Continuation Confirmation	1d	09/04/20	09/04/20	83	
85 Integration Enhancement Plan Continuation- (4 months)	16w	09/08/20	01/04/21	84	
86 4 month Status Report and Lessons Learned Due	20d	01/05/21	02/01/21	85	
87 - Integrated Care Practice Cohort 2 (up to 2 Practices)	690d	03/01/18	11/13/20		
88 - CHI Assessment Cohort 2 Baseline	41d	03/01/18	04/26/18		
89 CHI Assessment Administered	20d	03/01/18	03/28/18		
90 CHI Results Collected	20d	03/29/18	04/25/18	89	
91 CHI Report Delivered	1d	04/26/18	04/26/18	90	
92 - Participant Implementation Process Cohort 2 Round 1	181d	04/27/18	01/16/19		
93 Up to 2 Participants Selected for Integrated Care Practice Cohort 2	1w	04/27/18	05/03/18	91	
94 Integration Enhancement Project Team Created	4d	05/04/18	05/09/18	93	
95 Integration Enhancement Plan (IEP) Created	3w	05/10/18	05/31/18	94	
96 Cohort 1 IEPs Due to Network4Health	0	05/31/18	05/31/18	95	
97 Network4Health IEP Funding Review	8d	06/01/18	06/12/18	96	
98 IEP Funding Confirmation (B1 Integrated Care Project Advisory Board)	1d	06/13/18	06/13/18	97	
99 Intiate Implementation Plan - (6 months)	24w	07/03/18	12/21/18	98FS +13d	
100 3 month Status Report Due	14w	07/03/18	10/10/18	99SS	
101 6 month Status Report Due	27w	07/03/18	01/16/19	99SS	
102 - CHI Assessment Cohort 2 Follow-up 1 (Progress Assessment Checkpoint)	41d	12/03/18	01/31/19		
103 CHI Assessment Administered	20d	12/03/18	01/02/19	101FS -30d	
104 CHI Results Collected	20d	01/03/19	01/30/19	103	
105 CHI Report Delivered	1d	01/31/19	01/31/19	104	
106 - Participant Implementation Process Cohort 2 Round 2	151d	02/01/19	09/03/19		
107 Status Report and CHI Assessment Results Reviewed	1w	02/01/19	02/07/19	101, 105	
108 IEP Modifications and Continued Funding Requests Reviewed	2w	02/08/19	02/21/19	107	
109 IEP Continuation and Funding Continuation Confirmation	1d	02/22/19	02/22/19	108	
110 Integration Enhancement Plan Continuation- (6 months)	24w	02/25/19	08/12/19	109	
111 3 month Status Report and Lessons Learned Due	14w	02/25/19	06/03/19	110SS	
112 6 month Status Report and Lessons Learned Due	27w	02/25/19	09/03/19	110SS	
113 - CHI Assessment Cohort 2 Follow-up 2 (Progress Assessment Checkpoint)	41d	07/23/19	09/18/19		

	Task Name	Duration	Start	Finish	Predecessors	% Complete
114	CHI Assessment Administered	20d	07/23/19	08/19/19	112FS -30d	
115	CHI Results Collected	20d	08/20/19	09/17/19	114	
116	CHI Report Delivered	1d	09/18/19	09/18/19	115	
117	Participant Implementation Process Cohort 2 Round 3	146d	09/19/19	04/16/20		
118	Status Report and CHI Assessment Results Reviewed	1w	09/19/19	09/25/19	112, 116	
119	IEP Modifications and Continued Funding Requests Reviewed	1w	09/26/19	10/02/19	118	
120	IEP Continuation and Funding Continuation Confirmation	1d	10/03/19	10/03/19	119	
121	Integration Enhancement Plan Continuation- (6 months)	24w	10/04/19	03/26/20	120	
122	3 month Status Report and Lessons Learned Due	14w	10/04/19	01/16/20	121SS	
123	6 month Status Report and Lessons Learned Due	27w	10/04/19	04/16/20	121SS	
124	CHI Assessment Cohort 2 Follow-up 3 (Progress Assessment Checkpoint)	41d	02/26/20	04/22/20		
125	CHI Assessment Administered	20d	02/26/20	03/24/20	114FS +130d	
126	CHI Results Collected	20d	03/25/20	04/21/20	125	
127	CHI Report Delivered	1d	04/22/20	04/22/20	126	
128	Participant Implementation Process Cohort 2 Round 4	145d	04/23/20	11/13/20		
129	Status Report and CHI Assessment Results Reviewed	1w	04/23/20	04/29/20	123, 127	
130	IEP Modifications and Continued Funding Requests Reviewed	1w	04/30/20	05/06/20	129	
131	IEP Continuation and Funding Continuation Confirmation	1d	05/07/20	05/07/20	130	
132	Integration Enhancement Plan Continuation- (6 months)	24w	05/08/20	10/26/20	131	
133	3 month Status Report and Lessons Learned Due	14w	05/07/20	08/13/20	131SS	
134	6 month Status Report and Lessons Learned Due	27w	05/07/20	11/13/20	131SS	
135	Evaluation Metrics Reporting (Data - per approved metrics)	919d	07/01/17	02/08/21		
136	On-going data reporting for period ending 12/31/2017	153d	07/01/17	01/31/18		
137	Prepare evaluation plan measures	152d	07/01/17	01/30/18		
138	Submit	1d	01/31/18	01/31/18	137	
139	On-going data reporting for period ending 06/29/2018	152d	01/01/18	08/02/18		
140	Prepare evaluation plan measures	151d	01/01/18	08/01/18		
141	Submit	1d	08/02/18	08/02/18	140	
142	On-going data reporting for period ending 12/31/2018	155d	07/01/18	02/11/19		
143	Prepare evaluation plan measures	154d	07/01/18	02/08/19		
144	Submit	1d	02/11/19	02/11/19	143	
145	On-going data reporting for period ending 06/29/2019	152d	01/01/19	08/01/19		
146	Prepare evaluation plan measures	151d	01/01/19	07/31/19		
147	Submit	1d	08/01/19	08/01/19	146	
148	On-going data reporting for period ending 12/31/2019	155d	07/01/19	02/10/20		
149	Prepare evaluation plan measures	154d	07/01/19	02/07/20		
150	Submit	1d	02/10/20	02/10/20	149	
151	On-going data reporting for period ending 06/29/2020	153d	01/01/20	08/03/20		

	Task Name	Duration	Start	Finish	Predecessors	% Complete
152	Prepare evaluation plan measures	152d	01/01/20	07/31/20		
153	Submit	1d	08/03/20	08/03/20	152	
154	<input type="checkbox"/> On-going data reporting for period ending 12/31/2020	153d	07/01/20	02/08/21		
155	Prepare evaluation plan measures	152d	07/01/20	02/05/21		
156	Submit	1d	02/08/21	02/08/21	155	
157	<input type="checkbox"/> Process Milestones	1049d	01/01/17	02/08/21		25%
158	<input type="checkbox"/> Milestones for period ending 06/31/2017	152d	01/01/17	07/31/17		100%
159	<input type="checkbox"/> Develop Implementation Plan	152d	01/01/17	07/31/17		100%
160	Implementation timeline	152d	01/01/17	07/31/17		100%
161	Budget	152d	01/01/17	07/31/17		100%
162	Workforce Plan	152d	01/01/17	07/31/17		100%
163	Participant Selection	152d	01/01/17	07/31/17		100%
164	Organizational Leadership Sign-off	152d	01/01/17	07/31/17		100%
165	<input type="checkbox"/> Milestones for period ending 12/31/2017	153d	07/01/17	01/31/18		100%
166	Up to 20 Participating Practices have demonstrated progress towards Coordinated Care Practice	153d	07/01/17	01/31/18		100%
167	Up to 2 participants have demonstrated progress towards Integrated Care Practice	153d	07/01/17	01/31/18		100%
168	<input type="checkbox"/> Milestones for period ending 06/31/2018	151d	01/01/18	08/01/18		
169	Up to 40 Participating Practices have demonstrated progress towards Coordinated Care Practice	151d	01/01/18	08/01/18		
170	Up to 2 participants have demonstrated progress towards Integrated Care Practice	151d	01/01/18	08/01/18		
171	<input type="checkbox"/> Milestones for period ending 12/31/2018	154d	07/01/18	02/08/19		
172	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	154d	07/01/18	02/08/19		
173	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	154d	07/01/18	02/08/19		
174	<input type="checkbox"/> Milestones for period ending 06/31/2019	152d	01/01/19	08/01/19		
175	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	152d	01/01/19	08/01/19		
176	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	152d	01/01/19	08/01/19		
177	<input type="checkbox"/> Milestones for period ending 12/31/2019	155d	07/01/19	02/10/20		
178	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	155d	07/01/19	02/10/20		
179	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	155d	07/01/19	02/10/20		
180	<input type="checkbox"/> Milestones for period ending 06/29/20	153d	01/01/20	08/03/20		
181	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	153d	01/01/20	08/03/20		
182	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	01/01/20	08/03/20		
183	<input type="checkbox"/> Milestones for period ending 12/31/2020	153d	07/01/20	02/08/21		
184	Up to 40 practices participating in Cohort 1, 2, and Integrated Practice will achieve SAMHSA Level 2	153d	07/01/20	02/08/21		
185	Up to 2 Participating Practices have demonstrated progress towards Integrated Care Practice	153d	07/01/20	02/08/21		
186						
187						
188						
189						

Attachment_B1.2d

	Task Name	Duration	Start	Finish	Predecessors	% Complete
190						
191						
192						
193						
194						
195						

#	Social determinant	Question	Response options	Comment	Risk designation
1	Demographics	Are you Hispanic, Latino/a, or Spanish origin	___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	Should be allowed to choose multiple responses	None
1	Demographics	What is your race?	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	Should be allowed to choose multiple responses	None
2	Transportation	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	One response	Yes
3	Education	What is the highest level of school you have finished?	___Less than a high school degree, still in school	One response	None

#	Social determinant	Question	Response options	Comment	Risk designation
			<input type="checkbox"/> Less than a high school degree, not in school		
			<input type="checkbox"/> High school diploma or GED		
			<input type="checkbox"/> More than high school		
3	Health Literacy	How confident are you filling out forms by yourself?	1. Not at all	One response	Patient is considered "at risk" with responses 4 (Quite a bit) and 5 (Extremely)
			2. A little bit		
			3. Somewhat		
			4. Quite a bit		
			5. Extremely		
4	Language Preference	What Language are you most comfortable speaking?	<input type="checkbox"/> English	One response	None
			<input type="checkbox"/> Spanish		
			<input type="checkbox"/> Portuguese		
			<input type="checkbox"/> Chinese		
			<input type="checkbox"/> German		
			<input type="checkbox"/> Greek		
			<input type="checkbox"/> Hindi		
			<input type="checkbox"/> Italian		
			<input type="checkbox"/> Russian		
			<input type="checkbox"/> Arabic		
			<input type="checkbox"/> French		
			<input type="checkbox"/> Vietnamese		
			<input type="checkbox"/> Other		
5	Employment	What is your current work situation?	<input type="checkbox"/> Unemployed and seeking work		Patient is considered "at risk" with response: Unemployed and seeking work
			<input type="checkbox"/> Part time or temporary work		
			<input type="checkbox"/> Full time work		

#	Social determinant	Question	Response options	Comment	Risk designation
			__ Otherwise unemployed but not seeking work (ex. Student, retired, disabled, unpaid primary care giver).	One response	
6	Financial Strain	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 medications?	1. Not at all 2. Somewhat Hard 3. Very Hard	One response	Patient is considered "at risk" with responses 2 (Somewhat Hard) and 3 (Very Hard)
7	Housing	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	One response	Patient 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)
8	Family & Social Isolation	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	One response	Patient considered risk if answer is less than once a week

#	Social determinant	Question	Response options	Comment	Risk designation
8	Family and Social Isolation	How often do you feel isolated from others?	__1. Hardly ever	One response	Patient considered risk if answer is Often
			__2. Some of the time		
			__3. Often		
9	Legal issues	Have you or do you have any legal issue that are getting in the way of your health or well being?	__Yes	One response	Patient considered risk if answer is yes
			No		
10	Risk assessment	NIDA Screening: (See Sheet 2)	See sheet 2	One response per line	Patient is considered at risk if they answer monthly, weekly or daily
10	Risk assessment	PHQ-2 (see Sheet 2)	See Sheet 2	One response per line	Score >3
10	Risk Assessment	PHQ 2 Question 9 Only (see Sheet 2)	See sheet 2	One response	Score >0
11	ADL/IADL/Cognitive	Do you need assistance to complete any of the following?	__ Get out of bed	Multiple responses allowed	Patient considered risk if answer is yes to any
			Get Dressed		
			Climbing Stairs		
			Walking		
			Shop for Personal Needs		
			Prepare Meals		
			Use Telephone		
			Take your Medications as prescribed		
			Managing money		

#	Social determinant	Question	Response options	Comment	Risk designation
11	ADL/IADL/Cognitive	Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	One response	Patient considered risk if answer is yes
11	ADL/IADL/Cognitive	Have you fallen in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	One response	Patient considered risk if answer is yes
11	ADL/IADL/Cognitive	Do you ever feel unsteady when standing or walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	One response	Patient considered risk if answer is yes

NIDA Quick Screen Question:						
<u>In the past year</u> , how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily	
Alcohol <ul style="list-style-type: none"> 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						

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

#	Social determinant	Question	Response options	Comment	Risk designation
1	Demographics	Are you Hispanic, Latino/a, or Spanish origin	___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	Should be allowed to choose multiple responses	None
1	Demographics	What is your race?	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	Should be allowed to choose multiple responses	None
2	Transportation	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	One response	Yes
3	Education	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	One response	None

#	Social determinant	Question	Response options	Comment	Risk designation
			<input type="checkbox"/> More than high school		
3	Health Literacy	How confident are you filling out forms by yourself?	<input type="checkbox"/> 1. Not at all <input type="checkbox"/> 2. A little bit <input type="checkbox"/> 3. Somewhat <input type="checkbox"/> 4. Quite a bit <input type="checkbox"/> 5. Extremely	One response	Patient is considered "at risk" with responses 4 (Quite a bit) and 5 (Extremely)
4	Language Preference	What Language are you most comfortable speaking?	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> Chinese <input type="checkbox"/> German <input type="checkbox"/> Greek <input type="checkbox"/> Hindi <input type="checkbox"/> Italian <input type="checkbox"/> Russian <input type="checkbox"/> Arabic <input type="checkbox"/> French <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	One response	None
5	Employment	What is your current work situation?	<input type="checkbox"/> Unemployed and seeking work <input type="checkbox"/> Part time or temporary work <input type="checkbox"/> Full time work <input type="checkbox"/> Otherwise unemployed but not seeking work (ex. Student, retired, disabled, unpaid primary care giver).	One response	Patient is considered "at risk" with response: Unemployed and seeking work

#	Social determinant	Question	Response options	Comment	Risk designation
6	Financial Strain	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 medications?	1. Not at all 2. Somewhat Hard 3. Very Hard	One response	Patient is considered "at risk" with responses 2 (Somewhat Hard) and 3 (Very Hard)
7	Housing	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	One response	Patient 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)
8	Family & Social Isolation	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	One response	Patient considered risk if answer is Less than once a week
8	Family and Social Isolation	How often do you feel isolated from others?	__1. Hardly ever 2. Some of the time __3. Often	One response	Patient considered risk if answer is Often

#	Social determinant	Question	Response options	Comment	Risk designation
9	Legal issues	Have you or do you have any legal issue that are getting in the way of your health or well being?	__Yes	One response	Patient considered risk if answer is yes
			__No		
10	Risk assessment	Craft Part A (see Pre Adult Reference)	See sheet 2	One response per line	Patient is considered at risk if they answer monthly, weekly or daily
10	Risk assessment	PHQ-2 (see Adult Reference)	See Sheet 2	One response per line	Score >3
10	Risk Assessment	PHQ 2 Question 9 Only (see Adult Reference)	See sheet 2	One response	Score >0
11	ADL/IADL/Cognitive	Do you need assistance to complete any of the following?	_ Get out of bed _ Get Dressed Shop for Personal Needs Prepare Meals _ Use Telephone _ Take your Medication as prescribed _ Handle Finances	Multiple responses allowed	Patient considered risk if answer is yes to any
11	ADL/IADL/Cognitive	Have you or any of your family members noticed changes in your memory, language or ability to complete routine tasks?	_ Yes _ No	One response	Patient considered risk if answer is yes
				One response	Patient considered risk if answer is yes

#	Social determinant	Question	Response options	Comment	Risk designation
				One response	Patient considered risk if answer is yes

Box 1. The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:

- | | No | Yes |
|--|--------------------------|--------------------------|
| 1. Drink any alcohol (more than a few sips)?
(Do not count sips of alcohol taken during family or religious events.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Smoke any marijuana or hashish? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Use <i>anything else</i> to get high?
("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff") | <input type="checkbox"/> | <input type="checkbox"/> |

#	Social determinant	Question	Response options	Comment	Risk designation
1	Demographics	Are you Hispanic, Latino/a, or Spanish origin	<input type="checkbox"/> a. No, not of Hispanic/Latino/a, or Spanish origin <input type="checkbox"/> b. Yes, Mexican, Mexican American, Chicano/a <input type="checkbox"/> c. Yes, Puerto Rican <input type="checkbox"/> d. Yes, Cuban <input type="checkbox"/> e. Yes, another Hispanic, Latino, or Spanish Origin	Should be allowed to choose multiple responses	None
1	Demographics	What is your race?	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	Should be allowed to choose multiple responses	None
2	Transportation	In the past 12 months, has lack of transportation kept you from keeping your child's medical appointments, meetings, or from getting things needed for daily living?	<input type="checkbox"/> Yes <input type="checkbox"/> No	One response	Yes
3	Education	Are you enrolled in School	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Home Schooled <input type="checkbox"/> Not Applicable	One response	Answer NO

#	Social determinant	Question	Response options	Comment	Risk designation
3	Health Literacy	How confident are you filling out forms for your child?	1. Not at all 2. A little bit 3. Somewhat 4. Quite a bit 5. Extremely	One response	Patient is considered "at risk" with responses 4 (Quite a bit) and 5 (Extremely)
4	Language Preference	What Language is your child most comfortable speaking?	English Spanish Portuguese Chinese German Greek Hindi Italian Russian Arabic French Vietnamese Other	One response	None
6	Financial Strain	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 medications for your child?	1. Not at all 2. Somewhat Hard 3. Very Hard	One response	Patient is considered "at risk" with responses 2 (Somewhat Hard) and 3 (Very Hard)

#	Social determinant	Question	Response options	Comment	Risk designation
7	Housing	What is your housing situation for your child today?	<input type="checkbox"/> I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, in a car, abandoned building, bus or train station, in a park)	One response	Patient 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)
			<input type="checkbox"/> I have housing today but I'm worried about losing housing in the future		
			<input type="checkbox"/> I have housing		
8	Family & Social Isolation	How often does your child see or talk to people that you care about and feel close to?	<input type="checkbox"/> Less than once a week	One response	Patient considered risk if answer is Less than once a week
			<input type="checkbox"/> 1 or 2 times a week		
			<input type="checkbox"/> 3 to 5 times a week		
			<input type="checkbox"/> More than 5 times a week		
8	Family and Social Isolation	How often does your child appear isolated from others?	<input type="checkbox"/> 1. Hardly ever	One response	Patient considered risk if answer is Often
			<input type="checkbox"/> 2. Some of the time		
			<input type="checkbox"/> 3. Often		
9	Legal issues	Have you or do you have any legal issue that are getting in the way of your health or well being of your Child?	<input type="checkbox"/> Yes	One response	Patient considered risk if answer is yes
			<input type="checkbox"/> No		

#	Social determinant	Question	Response options	Comment	Risk designation
10	Risk assessment	Craft Part A (see Pre Adult Reference)	See sheet 2	One response per line	Patient is considered at risk if they answer monthly, weekly or daily
10	Risk assessment	PHQ-2 (see Adult Reference)	See Sheet 2	One response per line	Score >3
10	Risk Assessment	PHQ 2 Question 9 Only (see Adult Reference)	See sheet 2	One response	Score >0
11	ADL/IADL/Cognitive	Do you need assistance to complete any of the following for yourself or your child?	_ Get out of bed _ Get Dressed _ Shop for Personal Needs _ Prepare Meals _ Use Telephone _ Take your Medication as prescribed _ Handle Finances	Multiple responses allowed	Patient considered risk if answer is yes to any
12	Pediatric Development	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	Multiple responses allowed	Patient considered risk if answer is yes to any

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 - Family Physicians of Manchester	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center -Goffstown Family Practice	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Granite State Internal Medicine	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Highlander Way Internal Medicine	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Lakeview Internal Medicine	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Queen City Medical Associates	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Webster Street Internal Medicine	Yes	Yes	Progress	Progress	Progress	Progress	Progress
Catholic Medical Center - Healthcare for the Homeless	Yes	Yes	Yes	No	No	No	No
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

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 - Family Physicians of Manchester	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center -Goffstown Family Practice	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Granite State Internal Medicine	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Highlander Way Internal Medicine	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Lakeview Internal Medicine	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Queen City Medical Associates	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Webster Street Internal Medicine	Progress	Progress	Yes	Yes	Yes
Catholic Medical Center - Healthcare for the Homeless	No	No	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

Primary Care & Behavioral Health Organizations	Demographic Information	Physical Health Review	Housing Assessment	Educational Attainment	Family and Support Services	Access to legal services	Developmental Screenings
Elliot Health System - Elliot Primary Care at Bedford	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Pediatric Health Associates, Bedford	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Doctors Park Pediatrics, Manchester	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Pediatric Health Associates, Manchester	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliot Behavioral Health Services	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliot Pediatrics and Primary Care at Riverside	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliot Family Medicine at Hooksett	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Dr. Kenneth D. Thomas	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliot Family Medicine at Goffstown	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliot Family Medicine at Windham	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliot Pediatrics at Windham	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliot Primary Care at Londonderry	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Elliott Internal Medicine at Londonderry	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Senior Health Primary Care	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Briarwood Primary Care	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Elliot Health System - Derryfield Medical Group	Yes	Yes	Progress	Progress	Progress	Progress	Yes
Families in Transition / Family 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
Serenity Place*	No	No	No	No	No	No	No

Primary Care & Behavioral Health Organizations	Functional status assessment	Employment or entitlement	Depression Screening	Suicide risk assessment	Substance Use Review
Elliot Health System - Elliot Primary Care at Bedford	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Pediatric Health Associates, Bedford	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Doctors Park Pediatrics, Manchester	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Pediatric Health Associates, Manchester	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliot Behavioral Health Services	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliot Pediatrics and Primary Care at Riverside	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliot Family Medicine at Hooksett	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Dr. Kenneth D. Thomas	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliot Family Medicine at Goffstown	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliot Family Medicine at Windham	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliot Pediatrics at Windham	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliot Primary Care at Londonderry	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Elliott Internal Medicine at Londonderry	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Senior Health Primary Care	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Briarwood Primary Care	Progress	Progress	Yes	Yes	Yes
Elliot Health System - Derryfield Medical Group	Progress	Progress	Yes	Yes	Yes
Families in Transition / Family 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
Serenity Place*	No	No	No	No	No

BI Training Plan											
TRAININGS	Staff	B1: Core Series			Behavioral Health Series						
		Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	Recovery and Recovery Support	Prescription Drug Misuse and Abuse	Cultural Competence	Motivational Interviewing	
			includes substance use overview		includes data analytics & pop health & 42 CFR (Part 2)						
B1: Integration Participants											
	Catholic Medical Center										
BH	CMC Behavioral Health	Clinical Staff: 7 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Primary Care	Family Health & Wellness Center at Bedford	Clinical Staff: 14 Non-clinical staff: 4 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Primary Care	Highlander Way Internal Medicine	Clinical Staff: 4 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Primary Care	Hooksett Internal Medicine	Clinical Staff: 5 Non-clinical staff: 2 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Primary Care	Willowbend Family Practice	Clinical Staff: 15 Non-clinical staff: 6 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
	Dartmouth Hitchcock										

			Chronic Disease Series		
	<u>TRAININGS</u>	Staff	Diabetes/ Hyperglycemia	Dyslipidemia	Hypertension
	Catholic Medical Center				
BH	CMC Behavioral Health	Clinical Staff: 7 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
Primary Care	Family Health & Wellness Center at Bedford	Clinical Staff: 14 Non-clinical staff: 4 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
Primary Care	Highlander Way Internal Medicine	Clinical Staff: 4 Non-clinical staff: 3 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
Primary Care	Hooksett Internal Medicine	Clinical Staff: 5 Non-clinical staff: 2 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
Primary Care	Willowbend Family Practice	Clinical Staff: 15 Non-clinical staff: 6 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
	Dartmouth Hitchcock				

BI Training Plan											
			B1: Core Series			Behavioral Health Series					
	TRAININGS	Staff	Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	Recovery and Recovery Support	Prescription Drug Misuse and Abuse	Cultural Competence	Motivational Interviewing
			includes substance use overview		includes data analytics & pop health & 42 CFR (Part 2)						
B1: Integration Participants											
Primary Care	Dartmouth-Hitchcock Manchester	Clinical Staff: 144 Non-clinical staff: 35 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Primary Care	Dartmouth-Hitchcock Bedford	Clinical Staff: 31 Non-clinical staff:8 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
	Elliot Health System										
Primary Care	Elliot Family Medicine at Hooksett	Clinical Staff: 13 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Primary Care	Elliot Pediatrics and Primary Care at Riverside	Clinical Staff: 9 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Primary Care/BH	Manchester Community Health Center	Clinical Staff: 175 Non-clinical staff: 50 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018

		Chronic Disease Series			
	<u>TRAININGS</u>	Staff	Diabetes/ Hyperglycemia	Dyslipidemia	Hypertension
Primary Care	Dartmouth-Hitchcock Manchester	Clinical Staff: 144 Non-clinical staff: 35 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
Primary Care	Dartmouth-Hitchcock Bedford	Clinical Staff: 31 Non-clinical staff:8 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
	Elliot Health System				
Primary Care	Elliot Family Medicine at Hooksett	Clinical Staff: 13 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
Primary Care	Elliot Pediatrics and Primary Care at Riverside	Clinical Staff: 9 Non-clinical staff: 5 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable
Primary Care/BH	Manchester Community Health Center	Clinical Staff: 175 Non-clinical staff: 50 Target training numbers dependent on IEP by Q1 2018	not applicable	not applicable	not applicable

BI Training Plan											
			B1: Core Series			Behavioral Health Series					
	TRAININGS	Staff	Behavioral Health 101	Core Standardized Assessment	Integration in Practice	Mental Health First Aid	SBIRT	Recovery and Recovery Support	Prescription Drug Misuse and Abuse	Cultural Competence	Motivational Interviewing
			includes substance use overview		includes data analytics & pop health & 42 CFR (Part 2)						
B1: Integration Participants											
BH	Mental Health Center of Greater Manchester	Clinical Staff: 297 Non-clinical staff: 125 Target training numbers dependent on IEP by Q1 2018	Optional	Required by 12/31/18	Required by 12/31/18	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Dependent on IEP Q1 2018	Required by 12/31/18	Dependent on IEP Q1 2018
Support Services	Home Health and Hospice Care		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Crotched Mountain Community Care		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Granite State Independent Living		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Buhatenese Community of NH		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	Upper Room		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
Support Services	The Moore Center		Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional

			Chronic Disease Series		
	<u>TRAININGS</u>	Staff	Diabetes/ Hyperglycemia	Dyslipidemia	Hypertension
BH	Mental Health Center of Greater Manchester	Clinical Staff: 297 Non-clinical staff: 125 Target training numbers dependent on IEP by Q1 2018	Required by 12/31/18	Required by 12/31/18	Required by 12/31/18
Support Services	Home Health and Hospice Care		Optional	Optional	Optional
Support Services	Crotched Mountain Community Care		Optional	Optional	Optional
Support Services	Granite State Independent Living		Optional	Optional	Optional
Support Services	Buhatenese Community of NH		Optional	Optional	Optional
Support Services	Upper Room		Optional	Optional	Optional
Support Services	The Moore Center		Optional	Optional	Optional

Project C: Care Transitions-Focused

IDN Community Project Implementation and Clinical Services Infrastructure Plan

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

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.

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.

Overall Progress

Network4Health has made significant progress in its implementation of the Critical Time Intervention (CTI) program which is housed at the Mental Health Center of Greater Manchester. During the reporting period, Network4Health accepted our first client into the CTI program in late December, upon referral from Catholic Medical Center. Additional clients have entered the program since January 1st.

Network4Health has been successful in developing and posting job descriptions and hiring a CTI Director, a Care Transitions Administrative Worker and four of six CTI Coaches. New staff received appropriate training, including coach training in November 2017 and CTI Director/Supervisor training in December 2017.

Network4Health continues to work collaboratively with the other regions that are implementing the CTI initiative and Community of Practice (CoP) meetings, facilitated by Hunter College, began on December 20th. While training has begun, the training contract with Hunter College (across all participating regions) was not finalized as of the end of the reporting period.

Network4Health's individual mentoring of coaches from Center for Advanced Critical Time Intervention (CACTI) by phone did not begin before December 31st as we had just enrolled our first client, however this will begin February-March 2018. Assessment tools also continue to be developed. While Network4Health is working collaboratively across other IDNs that are implementing CTI, the IDNs are not all utilizing the same assessment tools as originally planned. The intake assessment has been finalized and is currently in use, but as of December 31st, Network4Health continues to consider potential Recovery Assessment tools and have discussions with the other participating IDNs.

Network4Health is most interested in using either the “Illness Management Recovery Scale” or the “RSA-R Recovery Scale”. Likewise, the Client Satisfaction Tool also is under consideration. However, Network4Health expects to have this tool finalized, whether collaboratively with or independent of the other regions, prior to our first client completing the CTI program. Network4Health has decided against using the Comprehensive Core Standard Assessment (CCSA) as part of C1 as CTI coaches are not appropriate for conducting the assessment. However, it will be used in the BI Integrated Healthcare Project and CTI coaches will provide information and support as needed.

Network4Health has finalized protocols for eligibility, enrollment, and each of the 3 program phases: Patient Transition, Patient Tryout and Patient Transfer of Care. These completed protocols are currently in use and described in more detail in section C-7 below.

Network4Health has developed additional performance measures for the program, in addition to what was initially included in our July submission. These measures are focused on continuity of care between treatment settings. Network4Health will now turn its attention to setting performance targets for these measures.

An updated project plan is included 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.*

As noted above, Network4Health developed additional performance measures focused on continuity of care across treatment settings during the reporting period. Our next step will be to develop reasonable performance targets. We expect that this will occur during this reporting period.

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		
Number of individuals completed program	Up to 333	0		
Average # days from transition to first BH outpatient visit				
Average # of mental health and substance abuse visits at end of Phase 1				
Average # of mental health and substance abuse visits at end of Phase 2				

Performance Measure Name	Target	Progress Toward Target		
		As of 12/31/17	As of 6/30/18	As of 12/31/18
Average # of mental health and substance abuse visits at end of Phase 3				
Increase # of community resource contacts from program enrollment to program completion				

C-3. IDN Community Project: Workforce Staffing

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

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

C-4. IDN Community Project: Budget

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

The following budget was submitted and approved as part of the Network4Health Semi Annual Report dated October 3, 2017.

C1 CARE TRANSITIONS TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
C1: Revenue (New)	\$451,560	\$451,560	\$477,120	\$477,120
C1: Revenue (Rollover)		\$170,482	\$97,340	\$35,024
Total Revenue	\$451,560	\$622,042	\$574,460	\$512,144
Salaries and benefits	\$210,000	\$426,300	\$439,089	\$428,598
Technology (Laptops, phones, software)	\$27,000	\$22,500	\$22,500	\$22,500

Barrier Reduction Funds (Client Emergency funds and Interpretation Services)	\$37,578	\$62,578	\$63,856	\$46,356
Occupancy Costs	\$6,500	\$13,324	\$13,991	\$14,690
Subtotal	\$281,078	\$524,702	\$539,436	\$512,144
Variation to Budget (Transfer Funds to Proceeding Year)	\$170,482	\$97,340	\$35,024	

At the time of initial payment, it was noted that the total revenue provided for all project budgets was slightly increased over expected. Network4Health had anticipated that the State would be distributing \$26,500,000 in available funding for CY 2017. However, the State distributed funding based on \$27,000,000 in available funding impacting 2017 and the following 3 calendar years. The total available funds for the four year period remain the same. We have adjusted revenue projections based on the revised distribution formula.

	CY 2017 (Yr2) Actual Expenses Posted	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
C1 CARE TRANSITIONS TRANSFORMATON FUNDS				
C1: Revenue (New)	\$460,024	\$460,024	\$460,024	\$477,061
C1: Revenue (Rollover)		\$448,903	\$294,239	\$124,842
Total Revenue	\$460,024	\$908,927	\$754,263	\$601,903
Salaries and benefits		\$496,300	\$509,089	\$498,598
Technology (Laptops, phones, software)	\$8,955	\$28,515	\$28,515	\$28,515
Barrier Reduction Funds (Client Emergency funds and Interpretation Services)		\$75,104	\$76,382	\$58,882
Occupancy Costs	\$2,166	\$14,769	\$15,435	\$16,134
Subtotal	\$11,121	\$614,688	\$629,422	\$602,129
Variation to Budget (Transfer Funds to Proceeding Year)	\$448,903	\$294,239	\$124,842	\$(226)

CY 2017 planned expenses were developed assuming a full six months of operations. Recruitment for the Program Director began in July with the position being filled part time in October. The Director became full time on January 2, 2018. (The C1 project director is funded by Project Design and Capacity Building Funds). The administrative support position was filled half-time at the beginning of December (becoming full time on January 1, 2018). 4 of six coaches were successfully recruited with two starting December 26, 2017 and two planning to start during January 2018.

The total expense paid during the reporting period was \$11,121.24. These expenses include technology and occupancy costs. While expenses were less than anticipated in CY2017, Network4Health anticipates that all planned expenses will be incurred in years 2018-2020 in the expense categories originally appearing in the budget.

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	Yes

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.

Standard Assessment Tool Name	Brief Description
Intake Assessment	The Self-Reporting Assessment will be facilitated by the Critical Time Intervention Coach or Director upon referral into 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 is continuing to coordinate with the other 4 IDNs that are implementing CTI and hope to use the same evidence-based tool that measures personal recovery. We are still considering two instruments: the "Illness Management and Recovery Scale" or the "RSA-R Recovery Scale." Both instruments are in the public domain, can be self-administered, take a consumer perspective to recovery, yield quantitative data from which we can monitor our progress, and have 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. It is our hope to use the same tool across all 5 IDNs implementing CTI. We will, at a minimum, include clients' 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 would they recommend it to friends and/or family members.
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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 3 or more of the following challenges: lack of positive social support/natural supports network inability to perform activities of daily living adequately, lack of basic subsistence needs (food stamps, benefits, medical care, transportation) inability to manage money, substance use with negative impact, employment challenges (e.g. unemployment, underemployed, or lack of employment skills) or suicide risk.	Currently in use
Enrollment	The CTI intervention is explained at an in-person meeting with the client and if the client agrees to enrollment, they will sign a consent to participate in CTI and will be enrolled 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 but 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 but provides little direct service. The CTI Coach allows the client to solve problems and together they develop and begin to implement a plan for long-term goals.	Currently in use
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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 of Network4Health
[REDACTED]	Care Transitions Director
[REDACTED]	Project Manager
[REDACTED]	Team Member

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

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

- The Center for the Advancement of Critical Time Intervention (CACTI) staff member(s) attended this meeting and presented background, evidence and brief overview of the CTI model and address questions from attendees. 10-15 participants from each of the 5 participating regions. Invitations also extended to DHHS and MSLC. Attendees from Network4Health included [REDACTED], NAMINH, [REDACTED], Center for Life Management, [REDACTED], Easterseals, [REDACTED], Network4Health, [REDACTED], Catholic Medical Center, [REDACTED], Child and Family Services, [REDACTED], Manchester

Community Health Center, ██████████, Hillsborough County House of Corrections, ██████████, Catholic Medical Center, and ██████████, 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 ██████████. These four individuals are providing oversight 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 (3/1/18 - 6/30/18)

- CACTI will plan, organize and deliver training on the CTI model which all Network4Health's CTI coaches will attend. This may be delivered via traditional in-person format (two days) or via distance training methods in collaboration with T3, CACTI's authorized distance training provider. All CTI direct service staff and CTI supervisors should participate in this training. Approximately 40 trainees from five regions are expected.

Phase 3 Coaching/Implementation Support to follow Program Launch

- **Community of Practice Meetings (12/1/17 -6/30/19)**
 - CoP meetings began in December 2017 and will occur monthly. These meetings of case managers and/or supervisors will allow providers to receive technical support during the implementation phase. A locally-based CACTI consultant will facilitate these meetings, with the goal of reducing their role as they help local trainers assume primary leadership responsibilities. Meetings may be held in-person or via web/phone depending on feasibility/cost issues.
- **Coaching Support for Individual Organizations (2/1/18 -12/31/20)**
 - Once individuals are enrolled in the CTI program, CACTI will provide monthly telephone consultation to case managers and supervisors at individual provider organizations. This will ensure program staff ample opportunity to receive and offer feedback, and will provide 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

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
C-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
C-2	IDN Community Project Evaluation Project Targets	Table				
C-3	IDN Community Project Workforce Staffing	Table				
C-4	IDN Community Project Budget	Narrative and Spreadsheet				
C-5	IDN Community Project Key Organizational and Provider Participants	Table				
C-6	Clinical Infrastructure: IDN Community Project 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	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_C1.1

ID	Task Mode	Task Name	Duration	Start	Finish			
						T	F	S
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
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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	

Attachment_C1.1

ID	Task Mode	Task Name	Duration	Start	Finish			
						T	F	S
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			

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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	

Attachment_C1.1

ID	Task Mode	Task Name	Duration	Start	Finish			
						T	F	S
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			

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	

Attachment_C1.1

ID	Task Mode	Task Name	Duration	Start	Finish			
						T	F	S
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			

Project: Care TransitionsPP.mpp Date: Mon 1/29/18	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	

Attachment_C1.1

ID	Task Mode	Task Name	Duration	Start	Finish			
						T	F	S
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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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	

Attachment_C1.1

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	
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	

Attachment_C1.1

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			

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	

Attachment_C1.1

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	
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	

Attachment_C1.1

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			

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	

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.

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.

During this reporting period, our project team has gone through some significant changes.

Network4Health's D3 project was driven by two key partners – the Elliot Health System and Serenity Place. Towards the end of September one of our project co-leads, who was a major champion for the Partial Hospitalization Program, left the Elliot Health System. Shortly thereafter our Executive Sponsor left the organization as well. Serenity Place, our key partner, was placed into receivership in late December. Families in Transition, the organization appointed to take over the programs at Serenity Place, has recently decided that they are unable to start up any new programs at this time. Lastly, the D3 Project Manager chose to take another position within the Elliot Health System.

Despite these obstacles we do have a major success story. In mid-November, Serenity Place, funded by N4H, hired a PHP Director who, through her experience, has catapulted our project plan into action and helped us to complete the following activities by December 31, 2017:

- Development of job descriptions for behavioral health clinicians
- Identified on-boarding requirements for both Serenity Place and Elliot Health System
- Development of assessment and screening tools
- Development and approval of intake policy and protocol
- Development and approval of patient assessment policy and protocol
- Development of treatment management policy and protocol

- Development of referral policy and protocol
- Development of billing policies and procedures
- Development of billing workflow
- Confirmation of Medicare/Medicaid billing and prior-authorization requirements
- Identification of a sister program for fidelity
- Development of evaluation schedule
- Development of intake workflow
- Development of referral workflow
- Development of program metrics
- Development of patient handbook
- Identification of training needs
- Development of training program including safety, crisis prevention and intervention, confidentiality, etc.

Due to the scarcity of workforce, the project team did have some difficulties recruiting for the Program Director position which was eventually filled in late November. Due to this delay and the subsequent receivership of Serenity Place, a few activities were either put on hold or not completed within the timeline.

- Interviews for clinical and administrative positions other than the Director's position
- Identification of personnel at Serenity Place and Elliot
- Advertise all open positions
- Basic training and orientation attended by all employees
- Identification of program equipment and supplies for phase I
- The development of brochures
- Marketing and education to referral sources
- PSA between Elliot and Serenity Place

Given the recent events with our partner, Serenity Place, Network4Health and the Elliot Health System have evaluated some options for the future of this project. Despite this set back, two things remain certain; the need for a partial hospitalization program for co-occurring conditions is significant in Manchester and our commitment to our mission is steadfast. Elliot Health System has offered to move forward with the PHP project independently. Although the planning that has been done thus far will be valuable as we chart our new course, the planning committee reconvened and decided a significant revision to the plan is required. At a high level, some of our considerations and research in the coming months will focus on space for the program, licensing and enrollment requirements and modifications/builds to the EHR. Our current project plan is included as Attachment_D3.1. The revised project plan will be completed on or before March 31st, 2018.

As described in our July SAR submission, in addition to adding a partial hospitalization program, Network4Health will also help to ensure expanded capacity for ambulatory and non-hospital inpatient medical monitored residential services, as well as hospital inpatient medically managed withdrawal

management services, as indicated for individuals with mental health, substance use or co-occurring disorders. Medication assisted treatment (MAT) and tobacco cessation are also provided across the system, as is comprehensive outpatient counseling for substance use disorders. These services are offered today by our Network4Health partners, and as described throughout our submission, services will be expanded through our efforts to address workforce issues, including reducing open positions and providing essential training and development for our staff. All providers will be working towards greater coordination and/or integration through our B1 project and implementing initiatives to move practices along the SAMHSA integrated care continuum, including integration of behavioral health assessment and services within practices. Our E4 project is focused specifically on increasing our partner's abilities to treat co-occurring disorders and is designed to enhance the capacity/competencies of serving people with co-occurring substance use disorders.

Examples of current services provided through Network4Health partners include ambulatory behavioral health services providing aftercare for substance-dependent clients discharged from acute detox; provision of outpatient detox; individual case management and peer support services; treatment for co-occurring disorders within a substance use setting; psychiatric services; comprehensive mental health outpatient services, including individual, family and group therapy and medication services. Examples of ongoing therapy groups include trauma recovery, anger management and relapse resistance. Providers utilize ASAM criteria to ensure that patients are receiving the appropriate level of care.

Through our B1 project, primary care practices will become coordinated and/or integrated and will receive extensive training including but not limited to how and when to give mental health assessments, recognizing triggers for involving behavioral health, and understanding the behavioral health referral process.

Network4Health partners strive to bring a person-centered approach that builds on each individual's strengths with counseling, therapies and medication management in the least restrictive community setting. Smoking cessation education and counseling is also provided across the system. Our goal is to help behavioral health patients make meaningful progress toward real recovery. Both the Elliot Health System and Catholic Medical Center have received grants to expand access to medication assisted treatment through primary care offices.

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.

Performance Measure Name	Target	Progress Toward Target
		As of 12/31/17
Performance specifications	PHP to comply with applicable requirements, including licensure, Bureau of Drug and Alcohol Services (BDAS) principles, as appropriate, and credentialing requirements of DHHS by 12/31/17	Credentialing of PHP Director is ongoing. Awaiting hiring of additional staff to start their credentialing. All regulations and guiding principles have been incorporated in all policies and protocols.
	Serenity Place to enroll in NH Medicaid program as a PHP by 12/31/17	Completed –unnecessary given current status of agency
	Serenity Place to enroll in Medicare as a PHP by 12/31/17	Completed –unnecessary given current status of agency
Length of stay	Re-evaluate program participants every 30 days, at a minimum.	As stated in the July 2017 submission, this measure is not applicable as the program has yet to begun.
Structural specifications	Include psychiatric treatment as part of the PHP program by 06/30/18	As stated in the July 2017 submission, this measure is not applicable as the program has yet to begun.
Number of individuals served	Up to 88 (total individuals in 2018)	As stated in the July 2017 submission, this measure is not applicable as the program has yet to begun.

Many of the evaluation project targets listed above will likely change and targets may be added in the new project plan.

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 recruitment and hiring of the PHP Program Director took longer than anticipated, with her start date being in late November. Once this position was filled, recruitment for the other positions began immediately. With Serenity Place going into receivership, however, all recruitment efforts have been put on hold until an alternate PHP plan is put into place.

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	0	1		
BH (MH & SUD) Clinicians – LMHC Counselor and/or LADC/MLADC Counselor	Up to 2	0	0		
Care Coordinator (i.e., Case Manager) – BSW, LNA or RN	Up to 1	0	0		
Care Enhancer (i.e. Peer Support Specialist) – Patient Advocate, CRSW or other national certification	Up to 1	0	0		
Care Coordinator – RN for medication management	Up to 1	0	0		
Psychiatric Clinician – Psychiatrist or Psychiatric Advanced Practice Nurse	Up to 0.6	0	0		
Care Enhancer (i.e. Outreach worker) – Community Health Worker	Up to 1	0	0		

D-4. IDN Community Project: Budget

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

The following budget was submitted as part of the Network4Health Semi Annual Report dated October 3, 2017.

D3 SUD EXPANSION TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
D3 Revenue (New)	\$451,560	\$451,560	\$477,120	\$477,120
D3 Revenue (Rollover)		\$351,653	\$(47,277)	\$3,548
Generated Revenue from Billing		\$220,880	\$662,640	\$1,104,400
Total Revenue	\$451,560	\$1,024,093	\$1,092,483	\$1,585,068
Salaries and Benefits	\$95,117	\$570,700	\$856,050	\$1,141,400
Sub-contractor Reimbursement		\$11,440	\$34,320	\$57,200
On-boarding	\$1,000	\$2,000	\$2,500	\$3,000
EMR licensing and implementation		\$423,000		
Lease		\$12,000	\$72,000	\$120,000
Equipment	\$500	\$12,000	\$30,000	\$34,000
Supplies	\$1,440	\$14,640	\$31,920	\$37,200
Food/Snacks		\$15,840	\$47,520	\$79,200
Travel		\$2,400	\$3,600	\$4,800
Marketing	\$750	\$750	\$1,125	\$1,500
Training	\$1,100	\$6,600	\$9,900	\$13,200
Subtotal	\$99,907	\$1,071,370	\$1,088,935	\$1,491,500
Variation to Budget (Transfer Funds to Proceeding Year)	\$351,653	\$(47,277)	\$3,548	\$93,568

At the time of initial payment, it was noted that the total revenue provided for all project budgets was slightly increased over expected. Network4Health had anticipated that the State would be distributing \$26,500,000 in available funding for CY 2017. However, the State distributed funding based on \$27,000,000 in available funding impacting 2017 and the following 3 calendar years. The total available funds for the four year period remain the same. We have adjusted revenue projections based on the revised distribution formula, and have updated based on actual spending as shown below. No funds were expended from this budget in CY2017. Due to a delay in hiring the Program Director, no expenses were incurred during this period (The D3 Director position, which was filled in November, is being funded by the Project Design and Capacity Building Funds). Because of the delay in filling the Director position, recruitment of additional staff did not begin until late in the reporting period. Network4Health anticipates that all planned expenses for CY 2017 will be incurred in years 2018-1-2020 and will be delineated with the revision to the original project plan. Due to the announcement regarding Serenity Place in late December, the budget may change for CY18, CY19 and CY20 as we reformulate our project plan.

D3 SUD EXPANSION TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
D3 Revenue (New)	\$460,024	\$460,024	\$460,024	\$477,061
D3 Revenue (Rollover)		\$460,024	(\$29,599)	\$4,130
Generated Revenue from Billing		\$220,880	\$662,640	\$1,104,400
Total Revenue	\$460,024	\$1,140,928	\$1,093,065	\$1,585,591
Salaries and Benefits	\$0	\$665,817	\$856,050	\$1,141,400
Sub-contractor Reimbursement		\$11,440	\$34,320	\$57,200
On-boarding	\$0	\$3,000	\$2,500	\$3,000
EMR licensing and implementation		\$423,000		
Lease		\$12,000	\$72,000	\$120,000
Equipment	\$0	\$12,500	\$30,000	\$34,000
Supplies	\$0	\$16,080	\$31,920	\$37,200
Food/Snacks		\$15,840	\$47,520	\$79,200
Travel		\$2,400	\$3,600	\$4,800
Marketing	\$0	\$750	\$1,125	\$1,500
Training	\$0	\$7,700	\$9,900	\$13,200
Subtotal	\$0	\$1,170,527	\$1,088,935	\$1,491,500
	\$460,024	(\$29,599)	\$4,130	\$94,091

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.

The Elliot Health System was working in partnership on the planning of the partial hospitalization program up until the end of December. On December 20th, Serenity Place was placed into receivership with Network4Health partner, Families In Transition, serving as the receiver. Subsequently, the Elliot has decided to implement a partial hospitalization program within their own health system, on behalf of Network4Health.

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. Each of the questions 5-17 is 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.

Protocol Name	Brief Description	Use (Current/Under Development)
Assessment and Service Planning	Policy and protocol for all screenings and assessments leading to and including admission to the PHP program.	Developed and awaiting approval from EHS

Protocol Name	Brief Description	Use (Current/Under Development)
Referral Policy and Protocol	Procedures for accepting referrals from other agencies and for facilitating referrals to other agencies for alternate levels of care.	Developed and awaiting approval from EHS
PHP Treatment Policy and Procedures	Policy and Procedures to insure that all regulations are met pertaining to PHP treatment standards, ASAM criteria, and medical necessity requirements. The policy details staffing levels, required treatment modalities, documentation requirements, the treatment planning process and discharge planning.	Developed and awaiting approval from EHS
Drug Testing	Policy and protocol to determine an appropriate use of random drug testing, the time intervals required and any reporting requirements	Developed and awaiting approval from EHS
American Society of Addiction Medicine – Patient Placement Criteria (ASAM PPC-2R)	The ASAM PPC-2R guidelines recognize that for persons with co-occurring disorders, the disorder that causes the most functional impairment should be considered in making the placement to a particular type of treatment setting. Treatment programs described in the PPC-2R may be either “dual diagnosis” capable or “dual diagnosis enhanced” to address persons with co-occurring disorders who have less stable or more stable mental health problems. For each level of treatment, criteria are specified (within dimensions two to six) for dual diagnosis capable and enhanced programs.	Developed and awaiting approval from EHS
Physical Detoxification Services for Withdrawal from Specific Substances	This protocol will include three components of the detoxification process: Evaluation, Stabilization and Client Entry into Treatment. It will detail both the medically required components/processes and the treatment recommendations	Under development

D-9. Provide the training plan and curricula for each Community Driven Project.

All staff will receive orientation on all policies, procedures and treatment schedules either prior to starting the program or shortly after joining staff. Ongoing training will be provided for staff involved in the screening, assessment and treatment of co-occurring disorders. Training will be provided in

understanding complicated symptom presentation, using integrated screening and assessment instruments, appropriate use of drug testing, differential diagnosis etc.

Education will be delivered weekly through educational modules supporting staff through the 12 Core Functions of Substance Use Disorders Treatment as well as the NBCC Counselor Competencies. Additionally, training in all ethical and safety concerns, such as confidentiality and universal precautions will be provided.

Content of these modules will be delivered in a formal training environment weekly in a classroom or conference room setting. Materials will be distributed a week prior to the training. These documents will contain the following: protocols and processes to complete required tasks, decision trees, further academic resources for continuing education, etc.

The chart below outlines the training plan and curricula that has been developed thus far. The curricula will be a fluid program. As more training modules are offered and developed in our network, the curricula may be updated. The timeline of mandatory completion will be provided in the update project plan.

Training	Type of Provider
Orientation	All providers and support staff
Effective Documentation	ARNP, RN, LCMHC, Case Mgr.
Policies and Procedures for PHP	All providers and staff
Confidentiality	ARNP, RN, LCMHC, Case Mgr.
Ethics and Clinical Boundaries	ARNP, RN, LCMHC, Case Mgr.
Assessment Tools	ARNP, RN, LCMHC, Case Mgr.
Safety in the Workplace	All providers and support staff
Counseling Skills (EBP's)	ARNP, RN, LCMHC, Case Mgr.
Developing Outcomes	ARNP, RN, LCMHC, Case Mgr.
Differential Diagnosis	ARNP, RN, LCMHC, Case Mgr.
Co-occurring Disorder Treatment	ARNP, RN, LCMHC, Case Mgr.
Suicidality and Crises Interventions	ARNP, RN, LCMHC, Case Mgr.
Family Training	ARNP, RN, LCMHC, Case Mgr.
Motivation Interviewing	ARNP, RN, LCMHC, Case Mgr.
Mental Health First Aid	All providers and support staff

Below is the training schedule and timeline for all providers and staff as developed prior to Serenity Place being placed into receivership. The timeline on the project will be re-evaluated based on the new project plan that will be provided by March 30th.

Training	Type of Provider	Date of Completion
Orientation	All providers and support staff	15-Jun-18
Effective Documentation	ARNP, RN, LCMHC, case mgr	15-Jun-18
Policies and Procedures for PHP	All providers and support staff	15-Jun-18
Confidentiality	ARNP, RN, LCMHC, case mgr	22-Jun-18
Ethics and Clinical Boundaries	ARNP, RN, LCMHC, case mgr	29-Jun-18
Assessment Tools	ARNP, RN, LCMHC, case mgr	6-Jul-18
Safety in the Workplace	All providers and support staff	13-Jul-18
Counseling Skills (EBP's)	ARNP, RN, LCMHC, case mgr	20-Jul-18
Developing Outcomes	ARNP, RN, LCMHC, case mgr	27-Jul-18
Differential Diagnosis	ARNP, RN, LCMHC, case mgr	3-Aug-18
Co-occurring Disorder Treatment	ARNP, RN, LCMHC, case mgr	10-Aug-18
Suicidality and Crises Interventions	ARNP, RN, LCMHC, case mgr	17-Aug-18
Family Training	ARNP, RN, LCMHC, case mgr	24-Aug-18
Motivation Interviewing	ARNP, RN, LCMHC, case mgr	31-Aug-18
Mental Health First Aid	All providers and support staff	7-Sep-18

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
D-1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
D-2	IDN Community Project Evaluation Project Targets	Table				
D-3	IDN Community Project Workforce Staffing	Table				
D-4	IDN Community Project Budget	Narrative and Spreadsheet				
D-5	IDN Community Project Key Organizational and Provider Participants	Table				
D-6	Clinical Infrastructure: IDN Community Project	Table				

Process Milestone Number	Process Detail	Submission Format	Results (Met/ Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
	Standard Assessment Tools					
D-7	Clinical Infrastructure: IDN Community Project Protocols For Patient Assessment, Treatment, Management, and Referrals	Table				
D-9	Provide the training plan and curricula for each Community Driven Project as required in A-1.3	Training schedule and table				

Project: D3 SUD Expansion

Today's Date: 12/31/2017 Sunday
(vertical red line)



Project Lead: [Redacted]
Start Date: 6/19/2017
Proposed End Date: 12/31/20

First Day of Week (Mon=2): 2

WBS	Tasks	Task Lead	Start	End	Duration (Days)	% Complete	Working Days	Days Complete	Days Remaining																								
										19-Jun-17	26-Jun-17	03-Jul-17	10-Jul-17	17-Jul-17	24-Jul-17	31-Jul-17	07-Aug-17	14-Aug-17	21-Aug-17	28-Aug-17	04-Sep-17	11-Sep-17	18-Sep-17	25-Sep-17	02-Oct-17	09-Oct-17	16-Oct-17	23-Oct-17	30-Oct-17	06-Nov-17	13-Nov-17	20-Nov-17	27-Nov-17
1	Hiring/Recruiting		7/1/17	3/31/20	1004	60%	717	601	403																								
1.1	Complete job descriptions		7/1/17	8/11/17	41	100%	30	41	0																								
1.2	Advertise (via respective organization)		7/1/17	12/31/17	183	80%	130	146	37																								
1.3	Conduct Interviews		7/15/17	12/31/17	169	60%	120	101	68																								
1.4	Evaluate Additional Staffing Needs for Phase 2		1/1/19	3/31/19	89	0%	64	0	89																								
1.5	Evaluate Additional Staffing Needs for Phase 3		1/1/20	3/31/20	90	0%	65	0	90																								
2	On-boarding		6/26/17	12/1/17	158	88%	115	139	19																								
2.1	Onboarding requirements		6/26/17	8/30/17	65	100%	48	65	0																								
2.2	Identify personnel at Elliot and Serenity Place		9/1/17	12/1/17	91	80%	66	72	19																								
3	Electronic Medical Record		2/1/18	12/31/19	698	0%	499	0	698																								
3.1	Generate EMR quote from Epic		2/1/18	6/30/18	149	0%	107	0	149																								
3.2	Negotiate contract with Epic		7/1/18	12/31/18	183	0%	131	0	183																								
3.3	Design and Implement EMR		1/1/19	12/31/19	364	0%	261	0	364																								
4	Forms/Assessment		7/1/17	12/31/17	183	100%	130	183	0																								
4.1	Identify Assessment and Screening tools		7/1/17	7/31/17	30	100%	21	30	0																								
4.2	Adapt patient Assessment and Screening tools for PHP		8/1/17	12/31/17	152	100%	109	152	0																								
5	Policies and Protocols		8/1/17	10/31/17	91	100%	66	91	0																								
5.1	Develop and approve Intake Policy & Protocol		8/1/17	8/31/17	30	100%	23	30	0																								
5.1.1	Develop and approve Patient Assessment Policy & Protocol		8/15/17	8/31/17	16	100%	13	16	0																								
5.2	Develop and approve Treatment Management Policy & Protocol		9/1/17	9/15/17	14	100%	11	14	0																								
5.3	Develop and approve Referral Policy & Protocol		9/15/17	10/1/17	16	100%	11	16	0																								
5.4	Develop and approve Billing Policy & Protocol		9/16/17	10/31/17	45	100%	32	45	0																								
6	Billing		6/26/17	11/1/17	128	40%	93	50	78																								
6.1	Confirm Medicaid & Medicare billing and pre-authorization		6/26/17	7/21/17	25	100%	20	25	0																								
6.2	Subcontract Agreement with Elliot		7/22/17	11/1/17	102	25%	73	25	77																								
7	Program Evaluation		6/19/17	9/1/17	74	100%	55	74	0																								
7.1	Determine program metrics		6/19/17	6/30/17	11	100%	10	11	0																								
7.2	Develop program evaluation (Myers & Stauter)		7/1/17	7/15/17	14	100%	10	14	0																								
7.3	Identify sister programs for fidelity		7/15/17	7/31/17	16	100%	11	16	0																								
7.4	Create evaluation schedule		8/1/17	9/1/17	31	100%	24	31	0																								
7	Fit-up/Construction		10/1/17	9/1/20	1066	2%	762	20	1046																								
7.1	Program equipment and supplies (Phase 1)		10/1/17	12/31/17	91	0%	65	0	91																								
7.2	Assess need for Expansion (Phase 2)		3/1/19	3/31/19	30	0%	21	0	30																								
7.2.1	Negotiate Lease		4/1/19	4/30/19	7	50%	22	3	4																								
7.2.2	New space fit-up/construction		5/1/19	9/1/19	7	0%	88	0	7																								
7.3	Assess need for Expansion (Phase 3)		3/1/20	3/31/20	30	0%	22	0	30																								
7.3.1	Negotiate Lease		4/1/20	4/30/20	7	0%	22	0	7																								
7.3.2	New space fit-up/construction		5/1/20	9/1/20	7	0%	88	0	7																								
8	Process Workflow		8/1/17	9/15/17	45	67%	34	30	15																								
8.1	Develop Intake workflow		8/1/17	8/15/17	14	100%	11	14	0																								
8.2	Develop Referral workflow		8/16/17	8/30/17	14	100%	11	14	0																								
8.3	Develop Billing workflow		9/1/17	9/15/17	14	0%	11	0	14																								
9	Training		7/1/17	1/8/19	556	95%	397	527	29																								
9.1	Identify Training needs		7/1/17	7/30/17	29	100%	20	29	0																								
9.2	Develop training Manual		11/1/17	11/30/17	29	100%	22	29	0																								
9.2.1	Safety		11/1/17	11/30/17	29	100%	22	29	0																								
9.2.2	Crisis Prevention and Intervention		11/1/17	11/30/17	29	100%	22	29	0																								
9.2.3	Justice		11/1/17	11/30/17	29	100%	22	29	0																								
9.3	Develop Patient Handbook		10/31/17	12/31/17	61	100%	44	61	0																								
9.4	Basic training – 5 day orientation for all staff; 2 day orientation at Elliot; and 3 day at Serenity		12/1/17	12/6/17	5	15%	4	0	5																								
9.5	Electronic training for the EMR		1/1/19	1/8/19	7	0%	6	0	7																								

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.

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.

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 indicated in our project plan, 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. The Dual Diagnosis Capability Assessor Team (DDC Assessors) consists of four individuals employed at partner organizations including Center for Life Management, Catholic Medical Center Behavioral Health and the Mental Health Center of Greater Manchester. In October 2017, [REDACTED], LICSW, MLADC joined Network4Health as the Co-Occurring Disorders Clinical Director. [REDACTED] has been working in direct clinical service for fourteen years, in locations throughout New Hampshire. Her experience includes working in many host settings including the legal and correctional system(s), a primary care office, and numerous school settings. In addition, 4 team members from Network4Health partner organizations applied to the Network4Health ITCOD project team to be trained as Dual Diagnosis Capability Assessors (DDC Assessors), as mentioned above. Network4Health DDC Assessors were hired as per diem consultants to the project, with funding provided to partner organizations to offset the cost of their time away from their employer and full-time roles. Per consultation from Case Western Reserve University's Center for Evidence Based Practice (CEBP), Network4Health provided a one day in-person Dual Diagnosis

Capability Assessors Training delivered by consultants from CEBP and had the Network4Health DDC Assessors shadow CEBP consultants across all stages of 2 Dual Diagnosis Capability in Mental Health Treatment Assessments and 2 Dual Diagnosis Capability in Addiction Treatment assessments at 4 Network4Health behavioral health organizations: The Mental Health Center of Greater Manchester, Serenity Place,¹ Families in Transition and Center for Life Management. The on-site assessment visits were completed in late September and October 2017, with at least 2 Network4Health DDC Assessors participating with the CEBP consultants for each of the 4 assessment organizations. Network4Health DDC Assessors participated in the entire lifecycle of the Dual Diagnosis Capability assessment process, including:

- Client Readiness Evaluation
- Assessment Scheduling and Structured Agenda Setting
- On-site Dual Diagnosis Capability Assessment
- Note compilation and Scoring Consensus
- Report Compilation and Recommendations
- Report Delivery

Per our project plan and evaluation metric, the team completed these 4 onsite Dual Diagnosis Capability assessments and created draft assessment reports within 2017. Due to scheduling and the availability of the CEBP team, 2 reports were delivered and presented to our partner organizations prior to December 31, 2017 and 2 reports were delivered in the first week of January, 2018. Network4Health is pleased to share that all 4 organizations were assessed within the score range for Dual-diagnosis capable (DDC) organizations. There are 35 benchmarks within the Dual Diagnosis Capability Index and while our partners all had a summary score within the DDC range, there was significant variation of where they fall within the designation range and also how they may have scored across the 35 program benchmarks, allocated across 7 dimensions of program structure. Scoring for a given program element includes both the existence of certain standards, as well as the frequency of an organizations ability to deliver that standard. An average score of 3 for each of the 35 program elements is indicative of a program that is capable of delivering services to some individuals, but has a greater capacity to serve individuals with only a mental health or substance use disorder. Dual-diagnosis enhanced designation is indicative of a program that can address both types of disorders fully and equally. The detailed scores for each of the 35 program benchmarks, cumulative scores for each of the 7 dimensions and the overall score for the program was provided to each organization. For each dimension, organizations are provided with detailed reasoning for their scores, as well as recommended areas of improvement. This information will be used in the creation of organizations Dual Diagnosis Capability Quality Improvement Plans for funding in early 2018.

In November and December, 2017, our Co-Occurring Disorders Clinical Director together with leadership from Serenity Place created the first Network4Health Dual Diagnosis Capability Quality Improvement Plan (DDC QIP). The DDC QIP identified 8 areas of focus for work to improve the delivery of services to patients with co-occurring disorders at Serenity Place. The DDC QIP received funding approval from the Network4Health Integrated Treatment of Co-occurring Disorders Project Advisory Board on December 19, 2017. Soon after approval, Network4Health was notified that Serenity Place was put under receivership. While Families in Transition, as receiver for Serenity Place, works to define their plan for the organization and the services they will offer going forward, Network4Health has put all funding for the Serenity Place DDC QIP on hold.

¹ Serenity Place was placed in receivership in December 2017. It is not clear whether the receiver will continue being involved in this project going forward.

Dual Diagnosis Capability Quality Improvement Plans to support the Mental Health Center of Greater Manchester, Families in Transition/Family Willows Treatment Center and Center for Life Management will be developed in early 2018.

Through this project, Network4Health also 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. Per our project plan, the Network4Health Co-Occurring Disorders Clinical Director, with input from ITCOD Project Advisory Board members, created a plan for the delivery of education materials and training to support this goal (see detailed information in section E-9).

As planned, the Network4Health Co-Occurring Disorders Clinical Director and Network4Health Executive Director completed a re-review and outreach to participating Network4Health organizations to identify additional treatment programs to be assessed utilizing the Dual Diagnosis Capability assessments in 2018. At this time, Pastoral Counseling Services is the only organization committed to participate in a new Dual Diagnosis Capability assessment in 2018, though several others have expressed interest and discussions continue. We continue to meet with our partner behavioral health organizations to identify programs ready for Dual Diagnosis Capability assessments in 2018. In parallel, we are identifying additional 2018 training opportunities focused on co-occurring disorder treatment methodologies to offer behavioral health clinicians in our region.

As anticipated under the project plan, the ITCOD Director developed and disseminated the first edition of the bi-annual newsletter, aimed at informing all Network Partners in Region 4 of the activities of the ITCOD Project (Attachment_E2.1a). The first publication included information about the ITCOD Director and DDC Assessment Team, as well as the DDCAT and DDCMHT. In addition, information about the Program Leader Training that is scheduled for January 2018, including how to register, was provided.

Progress Assessment

The ITCOD Director held a meeting with the DDC Assessor Team to gather feedback on their experience as an Assessor Team member. Positive feedback was received regarding the training and assessment shadowing experience. Assessors all expressed interest to expand their experience and training through the delivery of additional Dual Diagnosis Capability assessments with partner organizations.

A discussion was organized at the November 2017 Project Advisory Board, with representatives of three of the four agencies to share feedback regarding their experiences with the DDC assessment. Individual organizational feedback was also collected during DDC report delivery meetings. Participating organizations have indicated they are pleased with the strengths-based approach to the assessment. They also reported feeling supported by the Network4Health DDC Assessment Team and CEBP consultants throughout the process. Program leaders expressed hopefulness and continued interest in the development of their quality improvement plans to increase dual diagnosis capabilities at their organization. It is believed that through the implementation of QIPs at numerous agencies, along with increased education and training around the co-occurring disordered population, that Network Partners will be able to make positive changes not only within their own agencies to change identification of and treatment for the co-occurring disordered population, but also be able to create stronger community ties to partner agencies and help strengthen both the referral process, and the consistency of treatment delivery during the waiver period, and sustain beyond.

An updated project plan is included as Attachment_E2.1b.

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 be determined as part of the Dual Diagnosis Capability Quality Improvement Planning process with each participating assessment organization.	0 - per our project plan		
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		
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: <ul style="list-style-type: none"> • 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		
The number of patients served in evidence based integrated treatment of co-occurring disorders programs.	Targets will be determined as part of the Dual Diagnosis Capability Quality Improvement Planning process with each participating assessment organization.	0 - per our project plan		

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.

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		
Dual Diagnosis Capability Assessors	Up to 4 x .2 FTE	0	4 Per diem DDC Assessors		

E-4. IDN Community Project: Budget

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

The budget below shows the submission included as part of the Network4Health Semi Annual Report dated October 3, 2017 and, upon approval, Network4Health received the first installment of Calendar Year 2017 funding was received in November. At that time, it was noted that the total revenue provided for all project budgets was slightly increased over expected.

E4 INTEGRATED TX COD TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
E4 Revenue (New)	\$451,560	\$451,560	\$477,120	\$477,120
E4 Revenue (Rollover)		\$293,904	\$64,393	\$42,210
Total Revenue	\$451,560	\$745,464	\$541,513	\$519,330
Dual Diagnosis Capability Assessor Participation Offset (Training and Assessment Time)	\$21,681	\$56,846	\$45,619	\$45,619
Dual Diagnosis Capability Program Leader Training (2018) Attendee Participation Offset (up to 25)		\$23,100		
Dual Diagnosis Program Leader Training (2019) and Attendee Participation Offset (up to 16)			\$22,659	

E4 INTEGRATED TX COD TRANSFORMATON FUNDS	CY 2017 (Yr2)	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
Co-Occurring Disorders Capability Quality Improvement Plan Funds \$50,000 maximum per agency allocation for new QIP: Yr2: up to 2 agencies, Yr3: up to 10 agencies, Yr4&5: up to 2 agencies \$20,000 maximum per agency allocation for QIP continuation Yr 3, 4 & 5: Yr 3: up to 2 agencies, Yr4: up to 14 agencies, Yr 5: up to 16 agencies	\$105,000	\$567,000	\$399,000	\$441,000
NETWORK4HEALTH Assessor Training Course Development and Delivery		\$5,250	\$3,150	\$3,150
Integrated Treatment Tools & Training for Primary Care and Community Support Organizations	\$26,250	\$26,250	\$26,250	\$26,250
IT Budget COD Clinical Director (Laptop, Phone, etc.)	\$3,150	\$1,050	\$1,050	\$1,050
Occupancy Offset (COD Clinical Director)	\$1,575	\$1,575	\$1,575	\$1,575
Subtotal	\$157,656	\$681,071	\$499,303	\$518,644
Variation to Budget (Transfer Funds to Proceeding Year)	\$293,904	\$64,393	\$42,210	\$686

Network4Health had anticipated that the State would be distributing \$26,500,000 in available funding for CY 2017. However, the State distributed funding based on \$27,000,000 in available funding, impacting 2017 and the 3 following calendar years. We have adjusted revenue projections based on the revised distribution formula, as reflected below:

E4 INTEGRATED TREATMENT TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual Expenses Posted	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
E4 Revenue (New)	\$460,024	\$460,024	\$460,024	\$477,061
E4 Revenue (Rollover)		\$451,695	\$180,871	\$91,817
Total Revenue	\$460,024	\$911,719	\$640,895	\$568,878
Dual Diagnosis Capability Assessor Participation Offset (Training and Assessment Time)	\$6,848	\$61,791	\$50,563	\$50,563
Dual Diagnosis Capability Program Leader Training (2018) Attendee Participation Offset (up to 25)		\$23,100		

E4 INTEGRATED TREATMENT TRANSFORMATON FUNDS	CY 2017 (Yr2) Actual Expenses Posted	CY 2018 (Yr3)	CY 2019 (Yr4)	CY 2020 (Yr5)
Dual Diagnosis Program Leader Training (2019) and Attendee Participation Offset (up to 16)			\$22,659	
Co-Occurring Disorders Capability Quality Improvement Plan Funds \$50,000 maximum per agency allocation for new QIP: Yr2: up to 2 agencies, Yr3: up to 10 agencies, Yr4&5: up to 2 agencies \$20,000 maximum per agency allocation for QIP continuation Yr 3, 4 & 5: Yr 3: up to 2 agencies, Yr4: up to 14 agencies, Yr 5: up to 16 agencies		\$602,000	\$434,000	\$476,000
NETWORK4HEALTH Assessor Training Course Development and Delivery		\$5,250	\$3,150	\$3,150
Integrated Treatment Tools & Training for Primary Care and Community Support Organizations		\$35,000	\$35,000	\$35,000
IT Budget COD Clinical Director (Laptop, Phone, etc.)	\$1,218	\$1,694	\$1,694	\$1,694
Occupancy Offset (COD Clinical Director)	\$262	\$2,013	\$2,012	\$2,012
Subtotal	\$8,328	\$730,848	\$549,078	\$568,419
Variation to Budget (Transfer Funds to Proceeding Year)	\$451,695	\$180,871	\$91,817	\$459

Our CY 2017 planned expenses were developed assuming a full six months of operations. Recruitment for the Project Director began in July and the position was not filled until September. (The E4 Director position is being funded by the Project Design and Capacity Building Funds). This resulted in a delay in other project plan activities. Total expenses paid during the reporting period were \$8,328. These included salary and benefits, information technology and occupancy expenses. Network4Health anticipates that all planned expenses for CY2017 will be incurred in years 2018-2020 in the expense categories originally appearing in the budget and have been reallocated.

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.

Organization/Provider	Agreement Executed (Y/N)
Mental Health Center of Greater Manchester (MHCGM)	Y
Center for Life Management	Y
Families in Transition	Y
Serenity Place	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 not needed to modify the extensive list of tools provided in the July 2017 implementation plan. The team does not intend to dictate to network providers that all tools must be used. During organizational assessments and creation of a Quality Improvement Plan, Network4Health providers will select specific assessments to be used, if pertinent to their Quality Improvement Plan and treatment of patients with co-occurring disorders.

Standard Assessment Tool Name	Brief Description
<p>Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index Organizational Assessment Tool</p>	<p>The DDCAT index is designed to determine how effectively substance use treatment programs provide services for patients with co-occurring mental health disorders.</p> <p>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:</p> <ul style="list-style-type: none"> • Program structure • Program milieu • Clinical practice/assessment • Clinical practice/treatment • Continuity of care • Staffing • Training <p>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:</p> <ul style="list-style-type: none"> • Addiction-only services (AOS) • Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE) <p>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).</p> <p>An important purpose of the DDCAT evaluation process is to encourage treatment programs to improve every aspect of their care.</p>

<p>Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index Organizational Assessment Tool</p>	<p>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.</p> <ul style="list-style-type: none"> • Mental-health-only services (MHOS) • Dual-diagnosis capable (DDC) • Dual-diagnosis enhanced (DDE)
<p>The Mental Health Screening Form-III (Assessment/Screening)</p>	<p>Screening assessment for clients seeking SUD treatment to identify any co-occurring disorders. (SAMHSA TIP 42)</p>
<p>Simple Screening Instrument for Substance Abuse (SSI-SA) (Assessment/Screening)</p>	<p>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)</p>
<p>PHQ-9 Depression Screening (Assessment/Screening)</p>	<p>The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.</p>
<p>PHQ-2 Depression Screening (Assessment/Screening)</p>	<p>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.</p>
<p>Generalized Anxiety Disorder Screening (GAD 7) (Assessment/Screening)</p>	<p>Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder (GAD).</p>
<p>Addiction Severity Index (ASI) (Assessment/Screening)</p>	<p>The ASI is a general screening tool used extensively for treatment planning and outcome evaluation. (SAMHSA TIP 42)</p>
<p>Alcohol Use Disorders Identification Test (AUDIT) (Assessment/Screening)</p>	<p>The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health.</p> <p>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 alcohol involvement. (SMHSA TIP 42)</p>
<p>Beck Depression Inventory–II (BDI–II) (Assessment/Screening)</p>	<p>Used to screen for the presence and rate the severity of depression symptoms.</p> <p>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)</p>
<p>CAGE and CAGE-AID</p>	<p>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</p>

<p>Questionnaire</p> <p>(Assessment/Screening)</p>	<p><i>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).</i></p>
<p>Circumstances, Motivation, and Readiness Scales (CMR Scales)</p> <p>(Assessment/Screening)</p>	<p>SAMHSA TIP 42</p> <p><i>The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities.</i></p> <p><i>The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment.</i></p>
<p>Clinical Institute Withdrawal Assessment (CIWA-Ar)</p> <p>(Assessment/Screening)</p>	<p><i>Converts DSMIII-R items into scores to track severity of withdrawal; measures severity of alcohol withdrawal.</i></p> <p><i>Aid to adjustment of care related to withdrawal severity. (SAMHSA TIP 42)</i></p>
<p>Drug Abuse Screening Test (DAST)</p> <p>(Assessment/Screening)</p>	<p><i>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.</i></p> <p><i>Screening and case finding: Level of treatment and treatment/goal planning. (SAMHSA TIP 42)</i></p>
<p>Global Appraisal of Individual Needs (GAIN)</p> <p>(Assessment/Screening)</p>	<p><i>The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling. (SAMHSA TIP 42)</i></p>
<p>Level of Care Utilization System (LOCUS)</p> <p>(Assessment/Screening)</p>	<p><i>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)</i></p>
<p>Michigan Alcoholism Screening Test (MAST)</p> <p>(Assessment/Screening)</p>	<p><i>Used to screen for alcoholism with a variety of populations.</i></p> <p><i>(SAMHSA TIP 42)</i></p>
<p>M.I.N.I. Plus</p> <p>(Assessment/Screening)</p>	<p><i>Assists in the assessment and tracking of patients with greater efficiency and accuracy.</i></p> <p><i>(SAMHSA TIP 42)</i></p>
<p>Psychiatric Research Interview for Substance and Mental Disorders (PRISM)</p> <p>(Assessment/Screening)</p>	<p><i>The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and cooccurring disorder treatment samples.</i></p> <p><i>(SAMHSA TIP 42)</i></p>

Readiness to Change Questionnaire (Assessment/Screening)	<i>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)</i>
Recovery Attitude and Treatment Evaluator (RAATE) (Assessment/Screening)	<i>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)</i>
Structured Clinical Interview for DSM-IV Disorders (SCID-IV) (Assessment/Screening)	<i>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)</i>
Substance Abuse Treatment Scale (SATS) (Assessment/Screening)	<i>To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder. (SAMHSA TIP 42)</i>
University of Rhode Island Change Assessment (URICA) (Assessment/Screening)	<i>The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items. (SAMHSA TIP 42)</i>
Clinical Opiate Withdrawal Scale (COWS) (Assessment/Screening)	<i>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.</i>
Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Assessment/Screening)	<i>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</i>
PHQ-A (Assessment/Screening)	<i>Identifying depression in adolescents 11-17</i>
Brief Psychiatric Rating Scale (BPRS) (Assessment/Screening)	<i>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.</i>
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (Assessment/Screening)	<i>Screening to detect and manage substance use and related problems in primary and general medical care settings</i>

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. As noted above for assessments and screenings, treatment, management and referral protocols will be identified by each organization in alignment with evidence-based best practices as part of the DDCAT/DDCMHT organizational assessments. If a new protocol is identified through the development of Dual Diagnosis Capability Quality Improvement Plans, it will be added to the list. No new protocols were necessary based on Dual Diagnosis Capability Assessments completed in this reporting period.

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, Physician/Psychiatrist. The 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
Motivational Interventions (Treatment)	Motivational interventions include motivational interviewing, motivational counseling, 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 that provides recovery skills	Current

Counseling (Treatment)		
Group Treatment (Treatment)	<i>Research indicates that individuals with co-occurring disorders achieve better outcomes when they engage in stage-wise group treatment that addresses both disorders.</i>	<i>Current</i>
Self Help Groups (Treatment)	<i>Self-help groups are excellent sources of social support for individuals who are motivated to achieve and maintain abstinence.</i>	<i>Current</i>
Family Psychoeducation (Treatment)	<i>Family psychoeducation fosters social support. It includes consumers, caregivers (family members and friends), and service providers in the treatment process.</i>	<i>Current</i>
Pharmacological Treatment (Treatment)	<i>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</i>	<i>Current</i>
Interventions to Promote Health (Treatment)	<i>Research indicates that individuals with co-occurring disorders are at increased risk for poor health. Treatment team members encourage consumers to live healthy lifestyles</i>	<i>Current</i>

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.

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 monthly 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. In 2017, up to 4 team members and the Co-occurring Disorders Clinical Director will be trained as DDCAT/DDCMHT Assessors. The team will work together to provide DDCAT and DDCMHT assessments to participating organizations. The team completed initial training and will continue to receive consultative support from the dual diagnosis capability experts at Case Western Reserve University's Center for Evidence Based Practices. Additional training to enhance the DDC Assessment Team or replace due to turnover will be done using a train the trainer model in later years.

Integrated Treatment of Co-occurring Disorders (ITCOD) Practice Improvement Community:

Organizations participating in the Network4Health DDCAT/DDCMHT assessment process will be asked to join bi-yearly meetings of the Network4Health ITCOD Practice Improvement Community. The goal will

be to create a platform to share the ongoing dual diagnosis capability quality improvement efforts and identify increased opportunities for shared learning. Named participants for this community will be collected as organizations are scheduled for their DDCAT/DDCMHT assessment.

Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team:

Due to low participant interest, this team will not be formally called together. The Network4Health Dual Diagnosis Capability Clinical Director leads the planning effort around training and outreach to primary care and community support teams around patients with co-occurring disorders. She elicits feedback from members of the ITCOD Project Advisory Board on all plans.

Project Team Member	Roles and Responsibilities
<p>██████████ Network 4 Health/Mental Health Center of Greater Manchester</p>	<p>Executive Director, Network 4 Health <i>The Executive Director has overarching responsibility for the scope and direction of the Network 4 Health projects.</i></p>
<p>██████████ Network 4 Health/Mental Health Center of Greater Manchester</p>	<p>Co-Occurring Disorders Clinical Director, Network 4 Health <i>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.</i></p>
<p>██████████ Network 4 Health/Mental Health Center of Greater Manchester</p>	<p>Project Manager, Network 4 Health <i>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.</i></p>
<p>██████████ Mental Health Center of Greater Manchester (MHCGM)</p>	<p>Co-lead, ITCOD Project Advisory Team <i>See ITCOD Project Advisory Team description above.</i></p>
<p>██████████ Center for Life Management</p>	<p>Co-lead, ITCOD Project Advisory Team: <i>See ITCOD Project Advisory Team description above.</i> Dual Diagnosis Capability Assessor: <i>See Dual Diagnosis Capability Assessment Team above</i> DDC Primary Care and Support Team Member: <i>See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team</i></p>
<p>██████████ MHCGM</p>	<p>Dual Diagnosis Capability Assessor: <i>See Dual Diagnosis Capability Assessment Team above</i> ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above</i></p>
<p>██████████ MHCGM</p>	<p>Dual Diagnosis Capability Assessor: <i>See Dual Diagnosis Capability Assessment Team above</i></p>
<p>██████████ Catholic Medical Center (CMC)</p>	<p>Dual Diagnosis Capability Assessor: <i>See Dual Diagnosis Capability Assessment Team above</i> ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i></p>
<p>██████████</p>	<p>ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i></p>

Project Team Member	Roles and Responsibilities
██████████ Farnum Center/ Easter Seals NH	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ Granite Pathways	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i> DDC Primary Care and Support Team Member: <i>See Network 4 Health Dual Diagnosis Capability (DDC) Primary Care and Community Support Team</i>
██████████ Serenity Place	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ Southern NH Services/Rockingham Cap	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ The Upper Room	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ Elliot Health System	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ Hope for NH Recovery	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ Parkland Medical Center	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ Retired PCP Dartmouth Hitchcock System	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>
██████████ Parkland Medical Center	ITCOD Project Advisory Team Member: <i>See ITCOD Project Advisory Team description above.</i>

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

Completed Trainings

The following Network4Health trainings were completed prior to 12/31/2017. A list of participants is included below.

Dual Diagnosis Capability Assessor Training and Evaluation Shadowing

- DDCAT and DDCMHT Training (***Completed: September 9/27/2017***):
 - Conducting the evaluation
 - Item rating & consensus
 - Introduction to report writing
 - Introduction to report delivery & action planning
 - **Participants:**
 - ██████████ Network4Health Co-occurring Disorders Clinical Director
 - ██████████ Mental Health Center of Greater Manchester
 - ██████████, Catholic Medical Center Behavioral Health Services
 - ██████████ Network4Health Care Transitions Director
 - ██████████ Center for Life Management
- Evaluations and Shadowing (***Completed: 9/28/2017 – 10/30/2017***)
 - The CEBP consultants conducted the first 4 Network4Health DDCAT/DDCMHT assessments with members of the Network4Health DDC Assessment Team shadowing and learning from their work.

- **9/28/2017 DDCMHT : Mental Health Center of Greater Manchester**
 - [REDACTED], Center for Life Management
 - [REDACTED] Catholic Medical Center Behavioral Health Services
- **9/29/2017 DDCAT: Serenity Place**
 - [REDACTED] Mental Health Center of Greater Manchester
 - [REDACTED] Network4Health Care Transitions Director
- **10/16/2017 DDCAT: Families in Transition**
 - [REDACTED] Network4Health Co-occurring Disorders Clinical Director
 - [REDACTED] Mental Health Center of Greater Manchester
 - [REDACTED] Center for Life Management
- **10/17/2017 DDCMHT: Center For Life Management**
 - [REDACTED] Network4Health Co-occurring Disorders Clinical Director
 - [REDACTED] Catholic Medical Center Behavioral Health Services

Future Trainings

Dual Diagnosis Capability Program Leaders Training (Scheduled: 1/30/2018 – 1/31/2018)

- An instructor from Case Western Reserve University's Center for Evidence Based Practice (CEBP) will deliver 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 will also learn 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. Other key evidence-based tools for the integrated treatment of co-occurring conditions, such as motivational interviewing, may also be introduced in this training. All organizations participating in the Network4Health ITCOD sponsored DDCAT/DDCMHT assessments are scheduled to attend, except members of Serenity Place. Thirty-seven participants are currently scheduled to attend, including participants from other DSRIP IDNs.

In addition to our use of CEBP services, Network4Health will strive to promote and expand training services currently available within our partner organizations. We plan to provide:

Network4Health Assessor Training Course Development and Delivery

- All materials required to train future additional Network4Health Dual Diagnosis Capability Assessors was provided in the initial training by Case Western Reserve University. Currently, the 4 DDC Assessors are sufficient for the volume of Network4Health assessments. When needed, Network4Health will either contract for additional training through CEBP or utilize the Network4Health Co-Occurring Disorders Clinical Director to provide training. *(No planned dates, as all Assessors are currently fully trained; if new assessors are required then another training will be planned)*

Co-Occurring Disorders Quality Improvement Plan (COD QIP) Training and Technical Assistance

- Upon receipt of a DDCAT or DDCMHT assessment report and dual diagnosis capability continuum designation (Addiction-only services, Mental-health only services, Dual-diagnosis capable, Dual-diagnosis enhanced), participating organizations will document a Co-occurring Disorders Quality Improvement Plan (COD QIP). The one-year COD QIP will target training, process improvement, procedure modifications or other consultative services to help increase

the organizations competencies and program structure for the identification and integrated treatment of patients with co-occurring disorders. Where feasible, the Network4Health ITCOD Advisory Board will work to make trainings in support of a COD QIP available across participating organizations. There are no new trainings associated with an approved Quality Improvement Plan for this reporting period, but we expect some training in the next round of QIPs.

Trainings and services may include:

- DDCAT/DDCMHT Overview
- ITCOD (formerly IDDT) Clinical
- ITCOD (formerly IDDT) Implementation and Organizational Change
- Motivational Interviewing
- Stages of Change
- Critical Time Intervention (CTI)
- Cognitive Behavior Therapy (CBT)
- LEAP (Listen, Empathize, Agree, Partner)
- Medication Assisted Treatment
- Suboxone Treatment Protocol

Co-Occurring Disorders Training for Primary Care and Community Support Organizations

The 2018 Primary Care and Community Support Organization Training Plan aims to increase knowledge for both providers and consumers in the identification of co-occurring disorders, communication among providers and consumers, as well as treatment and available resources for individuals that are identified as having a Co-Occurring Disorder. The ITCOD Training plan includes numerous approaches to accomplish this goal including hard copy materials for providers and consumers alike to review and make available to all who access the organization, provided to each partner agency on a monthly basis. Topics will include mental health disorders, as well as substance use disorders as identified by the Diagnostic and Statistical Manual (DSM-5); including general information on symptoms, available evidence-based treatments and interaction among numerous disorders. In addition, the ITCOD Training Plan will offer trainings on basic identification and education on co-occurring disorders (including but not limited to Mental Health First Aid), for non-behavioral health professionals including administrative and front-line staff. More advanced trainings on evidence-based practices will also be offered- both as open trainings and reserved seats at existing community agency offerings (that may include but not be limited to: Integrated Dual Disorder Treatment (IDDT), Motivational Interviewing (MI) and Stages of Change (SOC). Evidence-based screening tools as noted in the July 2017 Semi-Annual Report such as the DAST, AUDIT, CAGE, SBIRT, PHQ-9, etc. will be provided and each agency will be encouraged to schedule and attend a lunch and learn or similar forum to review and discuss treatment application of such tools with the co-occurring disordered population.

Training Plan

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) <ul style="list-style-type: none"> - These hours are available to the Dual Diagnosis Capability Assessor team for support and continued learning around 	Up to 5	<i>Monthly sessions scheduled with Case Western Reserve University, Center for Evidence Based Practice Consultant</i>	12/28/2018
Program Leader Development			
Deliver Co-Occurring Disorders Program Leader Training	Up to 50	1/30-1/31/2018 <i>Scheduled</i>	3/30/2018
Primary Care and Support Organization Development			
Co-occurring Disorders Education for Primary Care Providers <ul style="list-style-type: none"> • Dissemination of hard copy materials • <u>Topics include:</u> 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 	All primary care provider practices	<i>Disseminated by the last day of each month in 2018</i>	Materials disseminated monthly on a selected topic (see list in title)

Co-Occurring Disorders			
Mental Health First Aid Training (8 hour training, maximum of 25 participants per course)	Up to 10 primary care or community support organizations	<i>A minimum of 1 training will be offered each quarter starting in April 2018</i> <i>Scheduled:</i> <i>-April 11/12- 2018</i> <i>To be scheduled prior to June 30, 2018:</i> <i>Summer 2018</i> <i>Fall 2018</i>	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	Up to 6 lunch and learns	<i>Up to 3 will be scheduled by June 30, 2018</i> <i>Up to 3 will be scheduled by September 30, 2018</i>	December 31, 2018
<i>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</i> <i>Scheduled Training Events include:</i>	Up to 160 seats for primary care or community support organizations	<i>Seats will be offered through 2018 as trainings become available.</i>	December 31, 2018
<i>Introduction to Addiction & Recovery</i> <i>This introductory workshop on addiction and recovery is designed to raise awareness and understanding of the</i>	50 seats	May 2018 <i>Scheduled</i>	May 31, 2018

<i>dynamics and impact of addiction on people whom we serve. It will cover the neurological basis of addiction; mental, behavioral, emotional and spiritual dimensions; stages of change; recovery; motivational techniques and resources.</i>			
<i>IHI Webinar Series: Virtual Expedition: Taking on the Opioid Crisis”. The web-based training series is offered as a single web/phone connection for a team to view together. Network4Health is offering 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.</i>	2 organizations	February – April 2018 <i>Scheduled webinars throughout timeframe</i>	May 2018

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

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

Process Milestone Number	Process Detail	Submission Format	Results (Met/Not Met)			
			6/30/17	12/31/17	6/30/18	12/31/18
E -1	IDN Community Project Timeline, Key Milestones and Evaluation Project Plan	Spreadsheet (Microsoft Project or similar platform)				
E -2	IDN Community Project Workforce Staffing	Table				
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	Table				

Process	Process Detail	Submission	Results (Met/Not Met)			
	Assessment, Treatment, Management, and Referrals					
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 (ITCOD) Newsletter

Welcome to the first issue of the ITCOD newsletter! The purpose of the newsletter is to inform our partner agencies within Region 4 of the current and upcoming happenings in relation to the N4H Integrated Treatment of Co-Occurring Disorders project/E4. Project E4 is issuing this newsletter as a part of our commitment to Performance Measures as set forth to the State of NH; you can expect more issues over the duration of the Waiver, on a bi-annual basis.

INSIDE THIS ISSUE:

What's happening?

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DDCAT/DDCMHT
Evaluations

3

Region IV Assessment

Team 4

Upcoming Events

5

What are Co-Occurring Disorders?“The term *co-occurring disorder* replaces the terms *dual disorder* ... when referring to an individual who has a co-existing mental illness and a substance-use disorder. While commonly used to refer to the combination of substance-use and mental disorders, the term also refers to other combinations of disorders (such as mental disorders and intellectual disability). Clients with co-occurring disorders (COD) typically have one or more disorders relating to the use of alcohol and/or other drugs as well as one or more mental disorders. A client can be described as having co-occurring disorders when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from another disorder”. (Psychology Today website)

360° View → The Power of Whole-Person Care



In any given year, there are approximately 34 million American adults with co-morbid mental and medical conditions. Coordinating care can improve clinical outcomes, increase care quality while reducing cost, and boost consumer satisfaction.

¹Source: New York State Office of Mental Health. ²Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). ³Source: Robert Wood Johnson Foundation. ⁴Source: Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E). ⁵Source: American Psychological Association. ⁶Source: Robert Wood Johnson Foundation. ⁷Source: Robert Wood Johnson Foundation.

What is Integrated Health Care? Integrated health care...is an approach characterized by a high degree of collaboration and communication among health professionals. What makes integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological and social needs of the patient. The interprofessional health care team includes a diverse group of members (e.g., physicians, nurses, psychologists and other health professionals), depending on the needs of the patient.” (APA Website)

REGION 4 CITIES AND TOWNS



*Atkinson *Auburn *Bedford *Candia *Chester *Danville
 *Deerfield *Derry *Goffstown *Hampstead *Hooksett
 *Londonderry *Salem *New Boston *Manchester *Plaistow
 *Sandown *Windham

What is Network4Health?

Network4Health (N4H) is a 43-partner integrated delivery network (IDN) established as part of NH's 1115 Transformation Waiver. The 1115 Waiver "Building Capacity for Transformation" has overall goals of integrating healthcare, expanding provider capacity and reducing gaps in care for people with behavioral health concerns. N4H Region 4 serves 18 communities surrounding Greater Manchester, Derry and Salem and has a total population of more than 320,000. Catholic Medical Center serves as the lead agency. Each IDNs is eligible for performance based funding through the delivery System Reform Incentive Payment (DSRIP).

ITCOD Project (E4)

This project has an overall goal of helping to increase knowledge of co-occurring disorders and working effectively with this population. The Director and a Team of Assessors work closely with the N4H Executive Director and partner agencies to towards quality measures and expectations.

Working with local mental health and substance use agencies, E4 will assess agency's current capability to provide treatment and support to the Co-Occurring Disorders population; while providing support for organizational growth to increase capacity and competency.

Network4Health Projects

Core Competency Projects:

Workforce Development Team (Project A1): Working to strengthen mental health and substance use disorder workforce.

Health Information Technology Team (Project A2): Develop health information technology to support integration of systems.

Integrated Healthcare Team (Project B1): Increase collaboration and integration between behavioral health and primary care services.

Community Driven Projects:

Care Transition Team (Project C1): Coaches trained to implement Critical Time Intervention to support individuals in their transition from institutions to the community.

Integrated Treatment of Co-Occurring Disorders (Project E4): Work with community agencies to assess current capability to provide treatment to the COD population and support their growth to increase their potential and services.

Partial Hospitalization Program (Project D3): Provide a program to serve dual disordered individuals in their recovery journey(s).

HELPFUL ACRONYMS

SUD: Substance Use Disorder(s)

N4H: Network for Health

DDCAT: Dual Diagnosis Capability for Addiction Treatment

DDCMHT: Dual Diagnosis Capability for Mental Health Treatment

COD: Co-Occurring Disorders

IDN: Integrated Delivery Network

MHCGM: Mental Health Center of Greater Manchester

FIT: Families in Transition

CLM: Center for Life Management

QIP: Quality Improvement Plan



On September 27, 2017,

████████████████████ from Case Western Reserve University provided an all-day training to the Assessment Team on the DDCAT (Dual Diagnosis Capability for Addiction Treatment) and DDCMHT (Dual Diagnosis Capability for Mental Health Treatment) which will be the tool used by the E4 Project (ITCOD).

The overall goal of the evaluation is to help an agency develop themselves in a way that makes sense to their staff and agency, while having additional support and funds to do so from the ITCOD Director and Assessment Team.

FAQs of the DDCAT/DDCMHT:

What: The DDCAT/DDCMHT Index is used to assess treatment agencies on their capacity to deliver services to people with co-occurring disorders. The DDCAT and DDCMHT provide a program-level assessment. Information is gathered during a site visit and drawn from assessor observations, interviews, and review of materials. These data are then used to complete ratings on 35 benchmarks regarding policy, clinical practice, and workforce domains.

Who: Agencies that provide clinical services to the COD population. Your agency works to identify a program to be assessed. The evaluation itself will be done by the ITCOD Director and another member of the Assessment Team.

Where: DDCAT/DDCMHT evaluation takes place over the course of one to two site visits at your agency.

When: When an agency expresses interest in the DDCAT/DDCMHT for their agency, there is an initial readiness call that takes place to discuss the process and help the agency prepare. If after that call the agency remains interested in completing the evaluation, the official site visit is scheduled.

Why: To help your agency consider its current capabilities in serving the COD population, and work to enhance the areas of capability your agency feels are the most important to your goals and mission. In turn, this will increase the availability and access to integrated care for our patients.

How: Information for the evaluation is gathered through numerous means including (but not limited to) a site visit with interviews of supervisors, clinical staff, clients and group observation, gathering of agency documents and policies.

Cost: Through the N4H Project, the initial evaluation, 6 month follow up evaluation, development and implementation of your QIP and support from the ITCOD Director is at no cost to your agency. There is also funding available to help support your agency's QIP Pan.



15 Ways to Beat the Winter Blues

- ☀ Eat a balanced diet
- ☀ Increase your vitamin intake through red, orange and dark green vegetables and fruit
- ☀ Get outside- ski, go for a walk, snowshoe, build a snowman
- ☀ Go to bed early
- ☀ Listen to music
- ☀ Expose yourself to natural sunlight
- ☀ Journal, work on a puzzle, color, read
- ☀ Talk to and spend time with people you care about
- ☀ Join a class (yoga, cooking, photography, painting, etc.)
- ☀ Limit sugar intake, including alcohol
- ☀ Stay hydrated
- ☀ Plan a vacation
 - ☀ Say “no” to something you don’t want to do
- ☀ Use mindfulness to increase awareness of your day to day activities
- ☀ Intentionally breathe deeply every hour

Meet Your Region 4 ITCOD Clinical Director



[Redacted]

[Redacted]

[Redacted] can be reached at [Redacted] Please feel free to reach out to introduce yourself and your agency, or ask any questions you may have! She and the Team of Assessors look forward to getting to know the partners throughout Region IV!

[Redacted]

Region 4 Assessment Team:

[Redacted]

UPCOMING EVENTS

***Dual Diagnosis Capability Program Leader Training:** This two-day training in January 2018 is aimed at agencies within the network that provide clinical services to clients with Co-Occurring Disorders. Registration is now open and we are hoping for a full house! If you have not received a link to the Event Registration and you feel as though your agency could benefit from attending, please contact [REDACTED] ITCOD Director at [REDACTED]

***Critical Time Intervention Training:** This two-day training in November 2017 is being offered to clinicians who will be part of the Care Transitions Team. This is the next step in developing the team and will allow them to receive referrals from the community and provide this Evidence Based Practice to clients to aid in their transition from institutions back to the community.

***Development and roll out of the 2018 Primary Care and Support Organization Training program** aimed to provide and increase knowledge surrounding the Co-occurring Disorders population for all agencies within Region 4.

***Delivery of DDCAT/DDCMHT Assessment Reports** to initial four agencies (CLM, MHCGM, Serenity and FIT). Following delivery of the final reports, development of individualized QIP will begin to support each agency in working towards their goal to help increase their capability to provide COD treatment.

***2018 DDCAT/DDCMHT Assessments** are currently being scheduled with additional agencies in the Region! Please reach out to [REDACTED] if you would like to learn more about the process and discuss the potential opportunity for your agency.

E4-ITCOD-12312017

Task Name	Duration	Start	Finish	Predecessors	% Complete
1 <input type="checkbox"/> N4H: Integrated Treatment of Co-occurring Disorders Implementation	936d	06/30/17	01/29/21		18%
2 <input type="checkbox"/> 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 <input type="checkbox"/> Training Plan	909d	07/03/17	12/24/20		37%
6 <input type="checkbox"/> 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 <input type="checkbox"/> Program Leader Development	147d	09/07/17	03/30/18		57%
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		
12 <input type="checkbox"/> 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 <input type="checkbox"/> DDCAT/DDCMHT Organizational Assessments	864d	09/04/17	12/24/20		11%
20 <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> January - June 2018	128d	01/02/18	06/28/18		
32 Deliver Up to 5 New Organizational Assessments (N4H Assessors)	105d	01/02/18	05/28/18		
33 Create Up to 5 Organizational Assessment Reports	90d	01/23/18	05/28/18		
34 Deliver Up to 5 Organizational Assessment Report Presentations	90d	01/23/18	05/28/18		
35 Create Up to 5 Dual Diagnosis Capability Quality Improvement Plans	70d	03/06/18	06/11/18		
36 N4H ITCOD Team Approves Funding for up to 5 Organization Dual Diagnosis Capability Quality Improvement Plans	72d	03/21/18	06/28/18		
37 <input type="checkbox"/> Progress Assessment Checkpoint	56d	04/02/18	06/18/18		
38 Evaluate status and completion feasibility for all in-progress Quality Improvement Plans	15d	04/02/18	04/20/18		
39 Modify in-progress Quality Improvement Plans (if required)	5d	04/23/18	04/27/18		

Attachment_E4.1b

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		
41 Gather Organizational Feedback from Dual Diagnosis Capability Reviews	10d	05/30/18	06/12/18		
42 Document feedback and any areas of improvement for future DDC reviews	2d	06/13/18	06/14/18		
43 Incorporate feedback into planning for DDC Review Documentation for N4H DDC Assessors	2d	06/15/18	06/18/18		
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		

Attachment_E4.1b

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		
105 Jan - June 2018 ITCOD Practice Improvement Community Meeting	128d	01/01/18	06/27/18		
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		14%
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		
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		21%

Attachment_E4.1b

Task Name	Duration	Start	Finish	Predecessors	% Complete
120 <input type="checkbox"/> 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 <input type="checkbox"/> January - June 2018	128d	02/01/18	07/30/18		
129 Implement data collection tool for Jan - June 2018 Assessment Organizations (post assessment)	106d	02/01/18	06/28/18		
130 Report number of individuals served (for organizations with approved Dual Diagnosis Capability Quality Improvement	21d	07/02/18	07/30/18		
131 Report Staff Recruited or Trained as part of Dual Diagnosis Capability Quality Improvement Plans	21d	07/02/18	07/30/18		
132 Report Network 4 Health project staff recruited, trained, staff turnover rate and vacancies	21d	07/02/18	07/30/18		
133 Report # of organizations assessed by DDCAT or CCMHT index	21d	07/02/18	07/30/18		
134 Report Assessed Organizations by Dual Diagnosis Capability Continuum Designation (AOS, MHOS, DDC, DDE)	21d	07/02/18	07/30/18		
135 Provide data on quality improvement plan work for each organization that may include: standardized assessment tools,	21d	07/02/18	07/30/18		
136 <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> Process Milestones by Reporting Period	914d	06/30/17	12/31/20		11%
159 <input type="checkbox"/> Period ending June 30, 2017	0	06/30/17	06/30/17		100%

Attachment_E4.1b

Task Name	Duration	Start	Finish	Predecessors	% Complete
160 <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> January - June 2018	73d	03/19/18	06/28/18		
179 Complete Schedule for January - June 2018 Dual Diagnosis Capability Organizational Assessments	0	03/19/18	03/19/18		
180 Deliver Co-Occurring Disorders Program Leader Training	0	03/30/18	03/30/18		
181 Complete up to 5 Dual Diagnosis Capability Organizational Assessments	0	05/29/18	05/29/18		
182 Complete up to 5 Dual Diagnosis Capability Quality Improvement Plans	0	06/12/18	06/12/18		
183 Complete Jan - June 2018 ITCOD Practice Improvement Community Meeting	0	06/28/18	06/28/18		
184 Deliver ITCOD e-Newsletter	0	06/28/18	06/28/18		
185 <input type="checkbox"/> 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 <input type="checkbox"/> 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		
200 Complete up to 2 NEW Quality Improvement Plans	0	12/09/19	12/09/19		

Attachment_E4.1b

	Task Name	Duration	Start	Finish	Predecessors	% Complete
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		

Alternative Payment Model (APM) Implementation Planning

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 detailed in our initial submission, there is limited APM activity ongoing in Region IV. However, Network4Health partners remain committed to working with the state to increase the use of APMs through the Medicaid program. Network4Health has been fully engaged with NH DHHS officials in the development of the DSRIP Alternative Payment Roadmap for Year 2 (CY2017) and Year 3 (2018) which has received approval from the Centers for Medicare and Medicaid Services (CMS).

On 11/1/2016, the NH DSRIP Learning Collaborative hosted a half day, all partners meeting with focus on Alternative Payment Models in Plymouth, NH. 20 individuals from Network4Health partner organizations attended.

The Office of Medicaid Services, with partners from the UNH School of Law and the NH Institute for Health Policy and Practice (IHPP), initiated a series of three meetings of the Statewide APM Stakeholder Workgroup. [REDACTED], Network4Health’s Executive Director, represents IDN Region 4. The first workgroup meeting was held on Friday, December 15, 2017. The second APM Roadmap Stakeholder meeting is scheduled for February 14, 2018.

There is some APM activity by Network4Health partners. For example, the 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. The Manchester Community Health Center participates in an APM with a Medicaid MCO as part of the Community Health Access Network. The Dartmouth Hitchcock Clinics in Manchester and Bedford participate in alternative payment models utilized by the NH Dartmouth Hitchcock system. Also, the acute care hospital partners have had experience with APMs in the commercial market as well as with Medicare.

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		
Develop an IDN-specific plan for implementing the roadmap which will contain IDN-specific outcome measures			
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
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			